



THE MODERN HOSPITAL

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NEW FIFTH AVENUE HOSPITAL EMBODIES STRIKING STRUCTURAL FEATURES

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BEFORE proceeding with a description of the physical features of the Fifth Avenue Hospital, it seems desirable to say something of the ideals around which this institution has been planned.

For several years prior to the World War, the board of trustees and the members of the medical staff of the Hahnemann Hospital contemplated the construction of a new plant to replace the old structure which had served the public of New York for upwards of fifty years, and after careful consideration it was decided that the new building should be so planned that the ideal type of hospital service would be available for all persons, irrespective of class, creed or color.

Facilities for Patients of Moderate Means

Investigation showed that the hospital problem had been pretty well solved for the extremely poor. The great city hospitals, as well as the privately endowed institutions, provide a modern ward service for those who are unable to pay.

And of course the person of unlimited means can secure a private room with bath, or even suites of rooms, equipped with all the modern conveniences known to hospital practice.

During this investigation the trustees and the members of the medical staff found that there was a great in-between class of people, who should, for their recovery's sake, have the type of hospital service available only to those of independent means.

These people are not well to do, nor are they poor. They do not want charity and they cannot afford luxury. To be placed in a large char-

ity ward or even a pay ward, would be a most depressing experience, and, on the other hand, paying the price for a comfortable private room would mean great financial strain at a time when they should be free from such worries. Then, too, it is the opinion of the members of the medical staff that to give a patient complete contentment of mind is to start him on the road to recovery.

To provide this in-between class with all of the necessary comforts and privacy of a single room is the great ideal around which this hospital has been constructed, but in order that all classes may be accommodated ample provisions have been made to care for the person of unlimited means, as well as for those who are extremely poor.

The rates authorized by the board of trustees are from "nothing up."

It was in accordance with this ideal, that the board of trustees directed the architects, York & Sawyer, together with Marc Eidlitz & Son, builders, and the writer as consultant, to prepare the plans for a single room hospital of three hundred beds capacity.

Central Idea is Concentration

The building, which is nine stories in height, with basement and sub-basement, is constructed on the plan of the letter X, and it is because of this design that each of the three hundred rooms is an outside room.

That the single room idea is one of the most striking features, goes without saying, but it should also be borne in mind that the scheme of organization and administration is of equal im-

portance. To plan a building containing all single rooms, would in itself present no particular difficulties, but when one considers the exacting demands of a modern hospital service, in connection with a building of this character, it is apparent that the scheme for organization and administration must receive special attention.

A glance at the floor plan will show that the idea of centralization of control was uppermost in mind in connection with the scheme of organization of this hospital, and one of the most important features is the central service department, located in the center of the main basement. It is flanked by the main kitchen, the diet kitchen, pharmacy, storerooms, surgical supply department and linen rooms. This central service department will receive all orders from the several floors, by means of the telautograph and the automatic telephone systems. The required articles will be transported by four electric dumb waiters and a large freight elevator, all of which are a part of the equipment of this department.

The surgical supply division will have charge of all sterilizing for the institution. Soiled instruments and dressings from the various floors will be transported by special dumb waiter to what is known as the disinfecting room, and, after having been properly cleaned and disinfected, will be passed into the sterilizing room and finally into the supply department for redistribution.

The main kitchen and special kitchen provide the food service for the entire hospital. Both of these rooms are lighted and ventilated by artificial means. The general diets are prepared in the main kitchen and transported to the floors by means of electrically heated trucks, each having a capacity of twenty-four trays. The service is direct from the serving table in the main kitchen to the bedside of the patient without re-handling on the floors. Special diets and liquid nourishments are prepared in the special diet

kitchen, and the dumb waiter service furnishes the means of transportation between the basement and the upper floors. The dish washing room, located nearby, takes care of all of the dish washing for the entire institution.

In the basement will also be found the locker rooms and dining rooms for maids and porters, storerooms and laundry.

In the sub-basement are located the boiler plant, the fan rooms, the morgue, the autopsy rooms, the disinfecting plant and the incinerator plant.

The first floor contains the administrative offices, the admissions department, the dining rooms for resident house staff and nurses, and living

quarters for interns, but on this floor will be found also a special feature in the form of private offices for physicians. In these offices they will be able to receive their private patients, and at the same time will remain in close touch with other patients in the hospital under their care. These suites of offices consist of a private reception room, an office and an examining room, and are so located that visiting patients will be admitted through a private entrance, and will not come into the hospital proper. This arrangement enables the physician to take advantage of the diagnostic facilities of the hospital, the benefits of

which will accrue to the visiting patients.

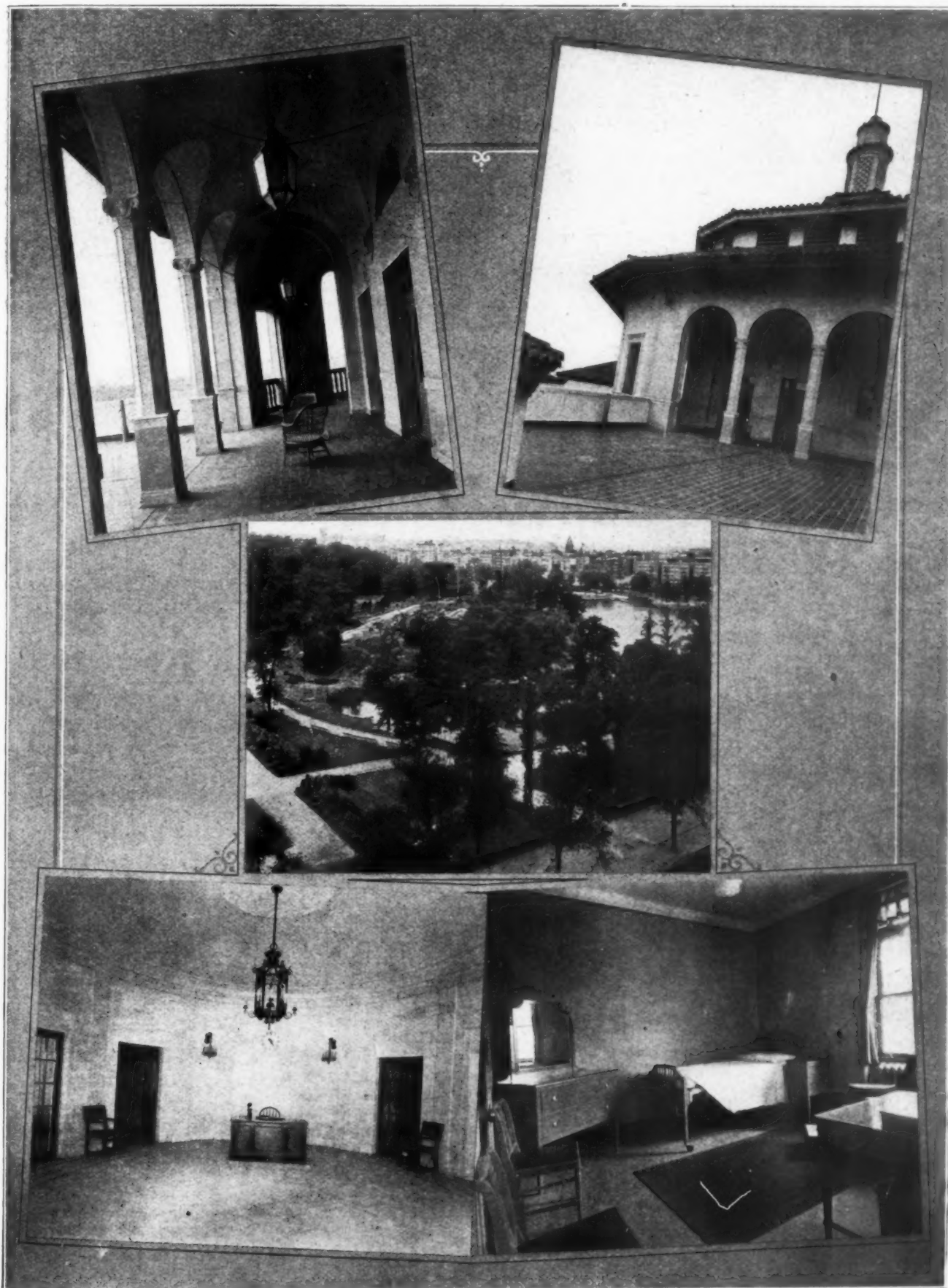
Another feature that should appeal to many is observed upon approaching the main entrance and rotunda. Here the visitor will note a complete absence of anything that might suggest a hospital atmosphere. Memorial tablets and marble busts are conspicuous by their absence, and the over-worked caduceus and other similar emblems which directly or indirectly remind one of sickness and suffering have given way to a simple but pleasing style of architectural treatment.

The second floor, which will be known as the Laura Franklin-Delano Foundation, will be used

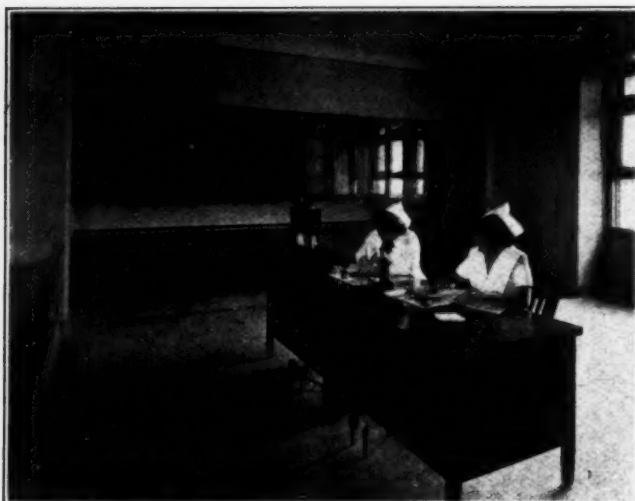


Front view of Fifth Avenue Hospital, showing a corner of Central Park.

FROM ROOF TO BASEMENT FIFTH AVENUE HOSPITAL CHALLENGES ATTENTION



A beautiful view of Central Park is seen from the roof of the hospital (center). Above are pictures of one of the loggias on the roof (left) and a corner of the roof itself; below are views of the rotunda and a patient's room.



The supervisor's office on the seventh floor commands a view of the elevator, the visitors' reception room and the service room.

exclusively for the care of children, and will be arranged in the form of large open rooms, together with a number of glass cubicles. The special arrangement of these rooms and cubicles with relation to the four distinct utility centers, insures elasticity of service and ready control. On this floor will also be found a school room for children, dental office, play rooms, dining rooms, as well as other facilities, and in addition there is a large open-air play roof which makes it unnecessary to take children to the main roof.

The arrangement of the third floor is typical of that of the fourth and fifth floors also. The four wings containing the patients' rooms, radiate from a central rotunda, around which are located the supervisor's office, the service pantry, the visitors' reception room, two passenger elevators, and directly back of the last mentioned, two completely equipped treatment rooms. The central location of the supervisor's office enables that official to have a direct view of the above mentioned departments. She may observe any one alighting from an elevator, and commands a view of the visitors' reception room, as well as the service room on the opposite side. Adjoining the supervisor's office is a small service room where special treatments may be prepared, and directly back of this room will be found the rest room for special nurses.

There are fifty-four single rooms on this floor, each furnished with a toilet, lavatory and necessary equipment. The rooms are from 8½ to 9 feet wide by 16 feet long, and it is these rooms that will be set aside for those who cannot afford the higher-priced rooms of the seventh floor. The equipment of each room with the fixtures already mentioned, insures prompt bedside service. In attending to the ordinary wants of the patient the nurse will travel approximately four feet from the bedside of the patient to the small toilet room, above described. Should special articles be required, the nurse may communicate directly with her supervisor by automatic phone.

The sixth floor, or maternity department, provides accommodations for thirty-eight adults and forty-five babies. Here you will find three delivery rooms, two for general use and one especially equipped for the care of infected cases. The color scheme for delivery rooms is French

gray throughout. Considerable attention was given to the old time problem of "noise" and through the use of glass doors, appropriately located, we have succeeded in isolating the labor rooms, delivery rooms and nurseries. In addition to this, the ceilings of the labor rooms and the nurseries have been made soundproof. The last mentioned feature has already proved its worth.

The rooms on the



Surgical supply room, showing dressing trays ready for distribution.



Pupil nurses' dining room, showing facilities for cafeteria service.

seventh floor are not unlike the rooms on the third, fourth and fifth floors, except that they are somewhat larger and a number of them have private baths. The construction of some of these rooms is so arranged that they may be used en suite if necessary.

The eighth floor is devoted entirely to the highly developed scientific departments.

The operating rooms, seven in number, occupy the northeast wing. Here will be found the clinic operating room with an amphytheater of modest proportions, two private operating rooms, a special operating room for genito-urinary cases and a cystoscopic room nearby. There are also special operating rooms for the eye, ear, nose and throat departments as well as a plaster room for the orthopedic service. In the general operating rooms there is one surgeons' scrub-up sink and one sterilizing unit for each of two rooms, and it may be well also to add that each operating room is provided with a recessed wall cabinet for dressings and supplies. The color scheme for the operating pavilion is similar to that in the delivery rooms of the maternity department, French gray throughout. One of the unusual features in connection with the arrangement of the anesthetic rooms is the complete absence of anything that will suggest a surgical operation. White marble walls and tile



The main kitchen is centrally located and with the diet kitchen provides the food service for the entire hospital.

floors are not in evidence. The rooms resemble small parlors and are furnished with curtains, wooden furniture, etc., the color scheme being a flat-finish buff. Special attention has been given to the ventilation of these rooms in order that the fumes of ether may be quickly removed.

The pathological and bacteriological laboratories occupy the southwest wing. The equipment is modern in every respect and in keeping with the hospital. One of the special features of this department is dumb waiter

service which transports all specimens directly from the several floors into the pathological department.

The department of gastro-enterology and x-ray occupies the entire southeast wing, and here will be found reception rooms, dressing rooms for patients, two exposure rooms, special examining rooms and fluoroscopic rooms.

In the northwest wing are located the examination and special treatment rooms for the department of medicine. These rooms will be equipped with electro-cardiograph, baso-metabolism apparatus, polygraph, electric wall plates, and other apparatus. Every facility necessary for the proper examination of the patient will be found in this spacious section.

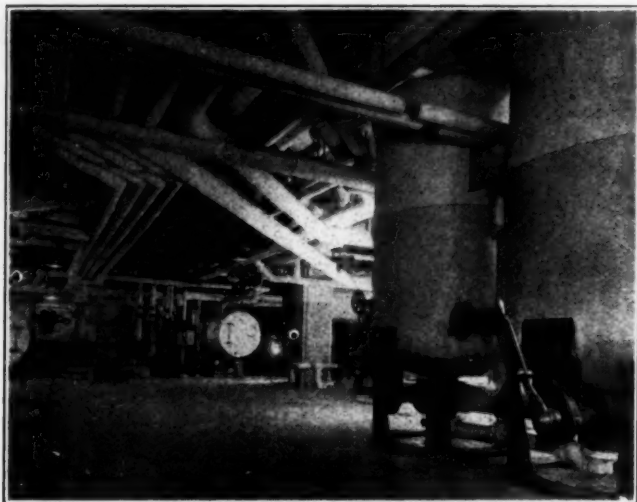
A reference library for all of the departments of this floor occupies a central location near the



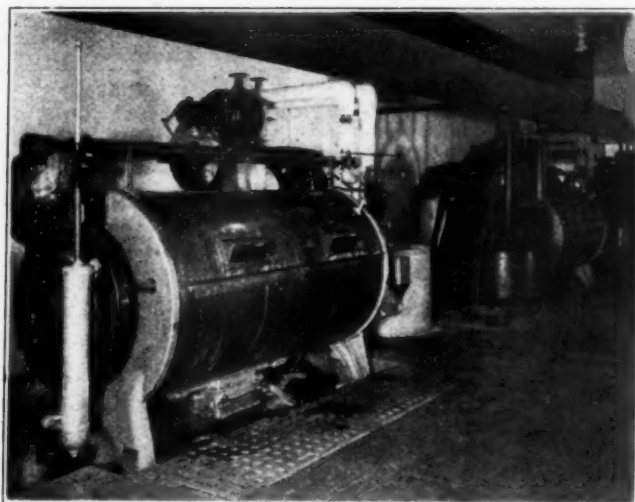
The special diet kitchen. This kitchen and the main kitchen are centrally located and provide the food service for the entire hospital.



The general operating room.



Sub-basement, showing thoroughly insulated pipes and tanks.



View of the wash room—laundry department.

front of the building, adjoining the open loggia overlooking Central Park.

The staff room, where staff meetings are to be held, is located on this floor and is completely equipped with the appliances necessary for the proper demonstration of cases.

The ninth floor is being used temporarily for pupil nurses, but upon completion of a nurses' home will be devoted to the care of convalescent patients.

The tenth floor, or roof, provides, in addition to the four open-air roofs, a large solarium for use during the winter season. Ample provision has been made for tray service to the roof. If desired, patients may remain on the roof all day and receive treatment and nourishment without interruption.

The foregoing description deals in a general way with the outstanding features of the Fifth Avenue Hospital, and one will readily understand that the central idea of the entire plan is concen-

tration. From the basement to the roof, this idea has been carried out and it is believed that as the details of the organization are perfected, the advantages of this centralization of control will become more apparent each day.

BUFFALO SUPERINTENDENT EXTENDS INVITATION

The Board of Managers of the Hospitals and Dispensaries of Buffalo, N. Y., of which Dr. Walter S. Goodale is the superintendent, issues an invitation to the members of the American Hospital Association to stop off at Buffalo on their way to or from their annual meeting to visit the Buffalo City Hospital. Extensive additions are being made to this hospital and the Honorable City Council of Buffalo has just appropriated an additional \$836,000 for the equipping and furnishing of the hospital. There will be a formal opening on October 1, 1922, when there will be thrown open to the public an institution costing \$3,500,000 and having a capacity of 836 beds.

CALIFORNIANS HOLD ANNUAL MEETING

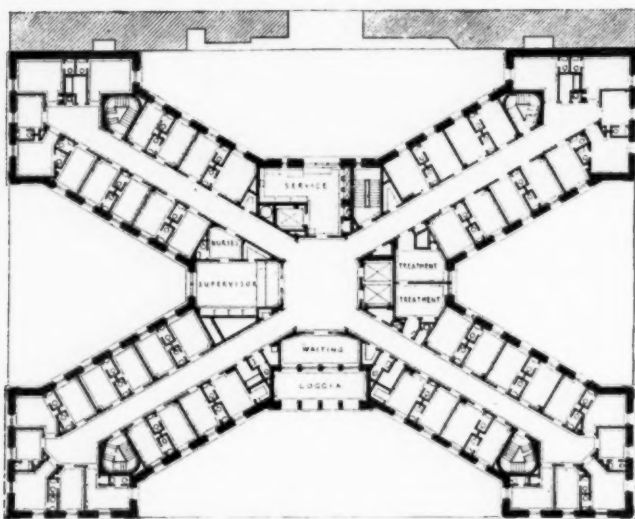
The second annual conference of the Hospitals of California, which is held under the auspices of the League for the Conservation of Public Health, will convene September 5-8 at the Maryland Hotel at Pasadena.

Some of the topics listed for papers and discussion at the various sessions include: general consideration of hospital problems; the physical hospital plant; owners, governing bodies and executives; clinical departments, including hospital and out-patient services; general utility departments, and hospital administration.

At the same time the Council of the Medical Society of California will meet at Pasadena.

OPENS SOCIAL SERVICE WARD

St. Mark's Hospital in New York has recently opened a free social service ward for women and children. Its purpose is to give careful and scientific study and treatment to cases involving venereal disease and allied problems in the personal and family relations. All social agencies, hospitals, dispensaries and physicians of the city are being urged to refer their patients to this ward.



Typical plan of third, fourth and fifth floors.

THE A B C MOVEMENT FOR HOSPITALIZATION IN THE COUNTIES OF MISSOURI

BY FRANK G. NIFONG, M.D., F.A.C.S., COLUMBIA, MO.

TO REPORT properly the modern rural hospital movement one must necessarily call attention to some of the problems to be solved in rendering medical service to the country people.

The writer has had the privilege of practicing medicine about an equal length of time in one of the larger cities and in a rural community. This has given him a dual point of view and a more correct appreciation of conditions to be met in both city and country. In considering the two, a contrast forcibly impressed upon him is the great handicap under which the country doctor renders medical service to country people, whether they be rich or poor. Our city folk are now supplied with the most modern hospital facilities for all classes, aided by group practice and apparently the ultimate in diagnostic facilities. In the country we have noble service but inadequate equipment and often poor facilities. We still have a few left of the old-time general practitioners. (God bless them!) These are the men who are giving more

ical education and improved opportunities to make use of the latest and best diagnostic and therapeutic aids. Doctors who serve in the country should be provided with improved equipment and better facilities.

The Need for Country Hospitals

The need for hospital service in the country has further been impressed upon the writer because we have here in Columbia a small hospital administered by the University of Missouri. This hospital is open to the citizens of Boone County, and it is rather conservative to estimate that through its service twenty-five or thirty lives are saved in the county yearly in emergency surgical cases alone. The rich and poor alike have needed this service. It is as essential that the wealthy citizen, if his life is to be saved, receive immediate hospital service as it is for the pauper, and there is no time to send to the city for a surgeon in emergencies. In this way the hospital need here has been emphasized and it has made the way easier



Audrain County General Hospital, Mexico, Mo.

real service in proportion to their opportunities than all the other groups combined, and it is devoutly to be wished that they may be kept in service for a long time to come. The best thing that could come to our country people (and to most of our city folk too, for they come chiefly from the country) would be a new supply of these doctors of the old school, with their ideals and altruistic service, modified only by a better med-

for the people to tax themselves for hospital purposes.

We know that our country people, those who produce our food, are the very foundation of our society and of our national existence. Anything we may do to make life more tolerable and more pleasant in the country goes far toward solving a great national problem. It is useless to cry, "back to the farm." We must give the workers on farms

equal advantage with the people in cities. We must give them good schools, good roads, and equally good hospitals and medical service.

State Medicine and Socialistic Schemes

Tendencies toward "state medicine" and socialistic schemes are showing themselves, and even now a note of warning is sounded in our na-

tion. A scheme could more quickly destroy our most altruistic and noble profession than one which destroys all individuality, ambition and incentive to work. The state provides for the welfare of the people by giving us good health laws and good boards of health and by fostering medical education; she should still further assist by giving us a comprehensive system of hospitalization, with



Callaway County General Hospital, Fulton, Mo.

tional and state medical organizations. Nothing could be more disastrous than that form of state medical service which attempts to give aid to the individual patient through the state hired doctor. The English "panel" game is abominable and would be worse if applied to our country.

But what are we to do? Modern scientific medicine is too intricate and too vast for either the country or the city doctor to compass it entirely. We must have team work. We must have our medical centers and our laboratories and all our work collaborated. Where may the country doctor get help, especially for his sick poor? The state must help him. It is state aid to the individual, isolated practitioner which must be furnished. The state should not attempt to treat its poor by paid agents; it should give aid to individual doctors with laboratory and like assistance. It is the state's business, and good business too, to care for all its derelicts, whether mental or physical. Our good State of Missouri has as her motto, "The welfare of the people is the supreme law." Welfare might reasonably be made synonymous with health, and the "health of the people" be made our supreme law. But the health of the people is not to be conserved by some abominable, socialistic scheme whereby medical service might be rendered by hired doctors apportioned to the poor of certain districts. The state must leave the medical man free to work unhampered. No

laboratory and diagnostic assistance for the country doctors.

Duty of the State to Its Sick Poor

Not only should the state care for its mental sick in psychopathic hospitals but for all other derelicts in a state general hospital. By a comprehensive system of hospitalization, a state general hospital, articulating with county and community hospitals, might well care for the sick poor of the state, as the poor of our better and larger cities are cared for. These poor people of the country must have this care, for they are as worthy and as important a part of our population as the city poor. It is a matter of justice and right, and it is a matter of extreme importance if we wish to keep our country people on the farms to produce our foods. We should have a state general hospital to which any indigent individual of the state may be sent for rehabilitation. We should have a state hospital with which may be articulated the county general hospitals. By this means we may have a great, coordinated system of hospital service over the entire state. We may standardize these articulated hospitals to certain grades of efficiency for the privilege of articulation and of being accredited. The state hospital might well become the supreme court in medicine, and to this court the isolated country doctor might bring his difficult cases and receive

the utmost benefit both for himself and his patient. This, then, should be our objective: a state and county hospital system which would give our poor as well as our rich people in the country, hospital advantages equal to those in cities.

Country People Need Modern Hospital

We must have as good medical service in the country as in the cities. How may we get it? The modern hospital must be given to the people in the country; otherwise it is impossible.

No one factor in modern scientific medicine is of greater importance and value than hospital service. It is the greatest aid; and it is essential in giving scientific, medical service. If it is the duty of the state and county units to care for the sick by making it possible for the medical profession to render the best and most scientific service possible, it is their duty to build, equip and maintain modern hospitals.

The importance of hospitalization and the great need for country hospitals is becoming increasingly evident. Note the recent prominence and the accented importance of the small community hospital. The people and the profession are awakening both to the possibilities and to the need of such service. The service which this class of hospitals can perform is of equal value to that of the metropolitan hospitals and may ultimately be of as great volume. The time will come soon when communities and counties will support hospitals unquestioningly and will submit to taxation for their support as they do for schools and roads.

The Limitations of Small Hospitals

We have listened on occasion to discussions on hospital administration and on what is necessary in staff work and nursing before an institution is worthy the name of hospital. We have also heard the small hospital anathematized and condemned most indiscriminately. We are fully aware of the deficiencies of small institutions and of certain limitations which they must have. The fact that these institutions have limitations and deficiencies, and some of them abuses, and the additional fact that they are increasing rapidly in response to a real need, makes it all the more important that hospital administrators give thought to their organization and lend all the aid possible in standardizing them and bringing them up to the highest possible level of efficiency.

These, then, are some of the reasons for this communication, a preliminary report, it may be called, on this new county hospital project in Missouri. We are, of course, in the experimental stage, a laboratory experiment in hospitalizing it may be called. We hope to benefit other com-

munities and countries by our failures as well as by our successes. We are pioneering.

Boone County Conditions

We have in Boone County a population of more than 30,000; Columbia, a town of about 12,000, has a student population during the season of about 5,000. We felt the need of hospital service for the rural population particularly; for, as explained before, the University of Missouri has only a small hospital serving the students and some of the citizens, and this situation simply accentuated our needs. How might we get a hospital? In 1916 we saw in *THE MODERN HOSPITAL* a notice of a county hospital law in Iowa and Indiana. We secured the Iowa statute and had it introduced, slightly modified, in our legislature, and it became our law in 1917. This law provides that any county may vote bonds and a tax for the erection and maintenance of a county hospital. A petition with 200 names subscribed, one-half in the county and the other half in the town in which the hospital is to be erected, is presented to the county court and the court calls an election. Our constitution makes it necessary that a two-thirds majority be obtained for the measure to carry. The first trustees are appointed by the court and afterwards elected at regular elections, two and three alternately. Trustees serve without



Boone County General Hospital, Columbia, Mo.

pay and are nonpartisan. The law gives the trustees absolute management, and they may make any rules they see fit to administer the institution. All legal practitioners of medicine may practice in the hospital, so long as they obey the rules laid down by the trustees. The trustees may exclude any patient or any physician for infraction of rules. A separate tuberculosis hospital may be built and administered by this board. The county court may apply five per cent of the revenue of the county for maintenance if it sees fit. A training school for nurses may be established. This, briefly, is the law.

Immediately after the war we felt more than ever our great need for such a hospital. The neighboring counties of Audrain and Callaway

which does all the fundamental work, and this is supplemented by having the Wassermanns and the pathological sections done by the medical department of the University of Missouri. This hospital is by law an "open hospital," and all legal practitioners have entree.

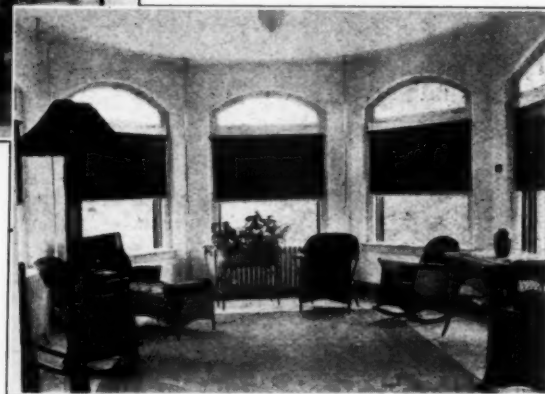
Many dangers might be pointed out which might easily arise: petty politics and lack of vision, inefficiency in management, and such things. It is extremely important that boards of trustees be men of character and capacity. Our counties have been extremely fortunate in having men, appointed by our courts, of high class and character. It has been very gratifying to medical men to see the interest and enthusiasm displayed by this board of trustees. We are convinced that, with a little care, we may always have men on these boards who will serve their people as disinterestedly as would a most ethical doctor. The selection of a superintendent is a difficult problem, and it gave our trustees more concern than anything else. We need more women nurses trained to administer small hospitals. We were fortunate in



Corner of lobby, Boone County Hospital.

first voted and found they had not asked enough to erect what they needed. They immediately voted for more money and received it. Boone County came next and made the same mistake, for building prices were at the peak. We asked for \$100,000, got our estimates, and found we needed more. We then asked for an additional \$75,000 and received it, when we let contracts for our plant. The assessment now is one and one-fourth mill, or \$1.25 per thousand, which, you will observe, is not heavy. We now have three beautiful hospitals in the three adjoining counties of Audrain, Boone and Callaway, and we are pleased to call this the A B C movement for county hospitalization. We are the pioneers in this state in this movement, and therefore regard it as an important experiment.

Now, as to our own Boone County Hospital. Our buildings were completed and the house was opened December 15, 1921. In the first five months of service we had received 275 patients. We employ all graduate nurses. We have a superior culinary service. We have an x-ray department doing daily service for house patients as well as for outside patients. We have a laboratory



The solarium at Boone County Hospital.

securing a woman superintendent of unusual ability; one with the ideals and practical good sense that will go far to show the way and work out our problems in the most practical way. When we reflect that the superintendent of a hospital must deal with all kinds of doctors as well as with all classes of patients, we realize that he or she should be a master in diplomacy. If we add to this the management of a nursing staff of variable capacity, the employment of common help of all grades of efficiency, running what is at once a hotel of superior quality and a house, with all the technical service and appurtenances pertaining to a hospital added on, it can readily be seen that exceptional ability as well as remarkable stability are required.

A staff seemed to be a difficult problem in an open hospital. We realized that no hospital is

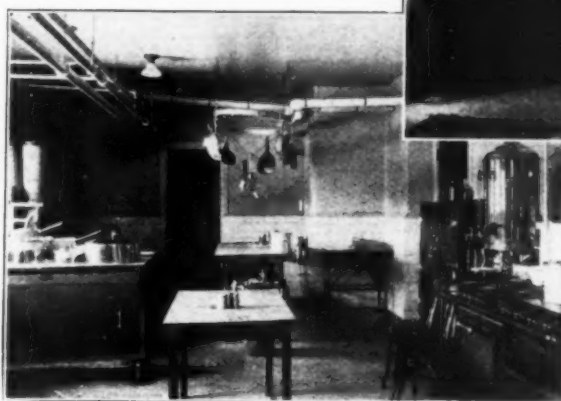
really worthy the name without a good working staff. How might we have such a staff? We have undertaken to solve that most important problem through the machinery of regular organized medicine. The Boone County Medical Society supplies the staff—a volunteer visiting staff. Individual members of the medical society have volunteered to the trustees to take over the various divisions of service, pledging themselves that they will care for all indigent patients or for all patients who may enter the hospital, and the hospital be paid for their service whether by individuals, churches, lodges or the county court. They also pledge themselves to serve in the out-patient department when that may be established.

We have regularly organized with a chief of staff, vice chairman, secretary, advisory committee, etc. We have a quarterly alternating service in internal medicine, general surgery, obstetrics, pediatrics, genitourinary and skin, gynecology, x-ray and laboratory; consultants on pathology, physiology and x-ray. We have lectures on public health and preventive medicine and

the work with great enthusiasm and vim. A higher standard is steadily being set, and improvement is noticed all along the line, even now. The more intimate association has increased good fellowship and understanding as well as mutual respect and good will. It looks like the objective through which good team work may be accomplished. We have staff meetings each month in which we review our cases and the work of the hospital. Anything for the good of the service is discussed. The monthly report is furnished from the office by the superintendent. Each death is particularly inquired into, and criticisms are both mercilessly and cordially made. We have a large room set aside on the fourth floor by our trustees for staff meetings and for the meetings of the



Patient's room at Boone County Hospital.



Boone County General Hospital kitchen.

volunteer inspectors of public school children. The executive committee of the staff acts in an advisory capacity to the trustees and superintendent. The chief of staff is an ex-officio member. We hope to open our out-patient department very shortly in the several departments, and will thereby increase greatly our field of usefulness. Under this plan you will see that we are using regularly organized medical men as our working staff. We volunteer as a unit and exclude thereby irregular, inefficient service. We also assume the responsibility of giving the best service, and it is "up to" the County Medical Society to make good. Every member of the county society has equal opportunity; there is no discrimination. It promises to become a matter of the survival of the fittest, or at least of the "workingest." So far the arrangement has worked most beautifully, and all are entering into

county society. Here also may be held other meetings having a health service side to them, such as mothers' clubs, inspecting and teaching school children and similar work. We are having installed a lantern and a moving picture machine which will help in our efforts to educate the children as well as ourselves.

We desire to make the Boone County Hospital function also as an educational force. We hope it may be a center from which will radiate every kind of activity which will promote health and well being. We feel that not the least important part to play is through an educational program. All our school children from the rural schools should be inspected here, and we hope to begin this inspection soon. While we have the children there we hope to teach them some of the elements of medicine and rules of good health. This is both easy and practical now, especially with the aid of visual education.

This, briefly, is some of our program and some of our problems. In time we contemplate having a nurses' training school, or perhaps a school for training nurses' assistants. At present we are using only graduate nurses. Our rates are exceed-

ingly low, being from \$2.50 per diem for the county patient to \$6 for the choicest room and bath, such as one would have to pay \$10 or \$12 for in a choice metropolitan hospital. Most likely these rates may have to be revised upward, especially if the county cases are very numerous. The revenue from the mill tax amounts this year to nearly \$50,000. About \$16,000 must be used for sinking fund and interest. Thirty thousand dollars will be available for maintenance and building. It is to be hoped that this, added to the income from pay patients, will make it possible to "break even" at the end of the year. Our law makes provision for the acceptance of gifts; no doubt they will be needed; they will certainly always be welcome. It is the desire to give not only the best service possible, but to render it to all classes of people.

We are also thinking of the future and of our increasing population. Our grounds are close in town and are four acres in extent, allowing plenty of room for expansion. Our buildings are planned for expansion, so that when additional wings are builded we may add seventy-five and again seventy-five beds, and ultimately have a 200-bed hospital. Also, we have room for a pavilion for infectious diseases, something much needed in a college town. An old residence on the property has been made into a nurses' home until such time as a modern one may be built.

In building and equipment up to this time, we have expended something like \$225,000.

Hospitals are somewhat costly; but the time has come when we must have them, even in the country. No investment pays bigger returns in health, welfare and happiness.

ELIMINATING FEAR FROM THE MIND OF THE SURGICAL PATIENT

The hospital doorman's smile and the telephone girl's voice, as well as the use of practical psychology by anesthetist, surgeon and nurse, have their place in eliminating the element of fear from the mind of the surgical patient, says Dr. Donald Guthrie of Sayre, Pa., in an article in a recent issue of the *New York State Journal of Medicine*. The personnel of the hospital, he declares, should be chosen with great care on this account. Little touches of human kindness will do much to rob hospitals of the cold institutional atmosphere which frightens many diffident patients and interferes with many satisfactory recoveries, he believes, and the surgeon and his co-workers must have a contagious optimism.

For this reason hotels and hospitals frequently and rightly employ fat doormen, for the fat man is usually good natured and cordial and slow to anger. A rasping, impatient voice of a telephone operator in the office of admission or the cold, business-like filling out of a questionnaire by some frigid clerk oftentimes gives the new arrival in the hospital the wrong impression of the spirit of the institution. A little display of cordiality and friendly feeling, says Dr. Guthrie, is by no means lost.

When the patient is admitted to the ward, the New York state doctor says, he should be waited upon promptly by attendants and nurses who have been specially trained. The patient must be spared seeing, smelling and hearing things which are objectionable. He should be admitted to a ward filled only with convalescent patients, who are happy and free from pain. Operative cases should never be moved into a big ward until they are out of pain, no painful dressing should be done on the ward, nor should a death be allowed to take place there. The mental peace of the new arrival should have this consideration, he asserts, for fear injected into the patient's mind at the beginning of his hospital stay is not conducive to a comfortable and quick convalescence.

Nor is it right to have operations delayed for an unnecessarily long time if there is nothing about the patient's case that justifies such a delay, Dr. Guthrie states. The surgeon or his associate should visit the patient the night before the operation and at this time assure him that his malady is curable, indicate the operation and set his mind at rest on his physical fitness for it. If possible he should be allowed to talk with convalescent patients who have had similar operations and have had quick and comfortable recoveries. The spirit to win, says Dr. Guthrie, is half the battle and the patient who feels, or can be made to feel, certain that he is going to come through a surgical ordeal usually does get well. On the other hand the patient who is convinced he is going to die before his operation, who fears that everything is being misrepresented to him, generally does die or have the most stormy sort of convalescence.

The night before operation must be spent in sound, restful sleep. Patients should not be dehydrated by pre-operative purges and their rest thus broken, in Dr. Guthrie's opinion. Most surgeons have discarded the castor oil or saline purge, and now rely upon the mildest of laxatives or enemas. Operations should be scheduled as early as possible in the morning so as to spare the patient the dreaded wait, the annoying thirst and the prostration from hunger. If for any reason, the operation cannot be performed until late in the morning or in the afternoon, he thinks the patient should be given warm fluids, such as tea, coffee or broths.

Two parts anesthetic and eight parts suggestion is the best mixture for the patient at the beginning of anesthesia, says Dr. Guthrie. The anesthetist must be a skilled psychologist and have a personality which can readily apply different kinds of suggestion to different individuals. He is the most valuable member of the operating team if properly trained and possessed of the right personality, the physician believes.

"All surgical patients must be examined by the surgeon or his associate before they are ready to leave the hospital," says Dr. Guthrie in conclusion. "At this time the patient's disease or operation should be explained to him in detail, all final instructions for his after-care carefully given him, besides telling him that his home physician will be written about his case. This gives him a sense of security at home, and the request that he write back a report of himself from time to time is met with delight, for he feels that the interest shown in him will not come to an end when he leaves."

ASSISTANT DIRECTOR AT MT. SINAI HOSPITAL

Dr. Joseph Turner, formerly superintendent, Eagleville Sanatorium, Eagleville, Pa., has been made second assistant director of Mt. Sinai Hospital, New York.

BRINGING CLIMATE TO THE PATIENT

BY W. DWIGHT PIERCE, PH.D., MANAGING DIRECTOR, BIOLOGICAL DEPARTMENT, THE MINERAL, METAL AND BY-PRODUCTS COMPANY, SAN MATEO, CAL.

ONE of the first steps made in the science of sanitation was in the direction of air-conditioning when the demand for pure fresh air became insistent. Through other incentives entirely there has arisen a science of air-conditioning which can give much of value to sanitary and medical science, and we will do well to consider what has been accomplished, what underlies the whole science, and how especially it can be applied in the field of health.

In general, we have known that air overcharged with carbon dioxide is unhealthy, and rules have been laid down specifying the maximum volume of carbon dioxide permissible in public buildings. But the student of air-conditioning now assures us that the capacity of the air to absorb carbon dioxide or any other gas and its danger to human health depends entirely upon the varying factors of temperature, atmospheric pressure and relative humidity. This fact was especially brought out in the report of the Departmental Committee on Humidity and Ventilation in Cotton Weaving Sheds (Cd. 4484, London, 1909). This report was necessitated by a desire to obtain satisfactory weaving conditions without too greatly affecting the health of the laborer, but its finding did not result in laying down any definite principles upon which a real science of air-conditioning could be built.

To the textile industry probably we owe the first serious efforts to control humidity in industrial establishments, as it was found that without sufficient atmospheric moisture static electricity interfered with the processes, the fibers were more liable to break and the fabric was not uniform. In fact, two very responsible engineering corporations have built up a large business through the development of systems of air-conditioning, including ventilation, air-washing, humidifying, dehumidifying, warming, cooling and drying. These systems are the gradual outgrowth of the demands of the textile industry and later other industries of many kinds to attain more suitable air conditions for their particular processes. These corporations have by individual plant studies worked out to the satisfaction of their clientele apparatus whereby the various plants have been able to improve the quality of their product in appearance or strength, or in some other manner, and much credit is due to them for their pioneer work.

But the field of air-conditioning is broader and

more vital than accepted by even these pioneers. It opens up visions of greater industrial health, greater personal efficiency and possibly a new principle of hospitalization. It is in the effort to bring these new ideas to the medical and sanitary professions that the present article was prepared.

Based on Principles of Sanitation

Expressing the basic principles in terms of the sanitarian and practitioner, we may set down a number of theorems which appear to be fairly well grounded at the present time.

(1) The normal physiological functioning of the body requires fresh air, or air not overcharged with carbon dioxide, or any other injurious gas.

(2) Modern industrial practice makes it possible to secure fresh air, or air made fresh by washing, and to maintain it at whatever combination of conditions may be specified by thermostatic automatic control.

(3) The quantity of carbon dioxide which may be held in suspension in the air with safety to the worker depends upon the factors of temperature, relative humidity and atmospheric pressure.

(4) The reactions of temperature upon living organisms can only be correctly thought of in terms of humid-temperature.

(5) At a given temperature the capacity of the air to absorb moisture depends upon atmospheric pressure.

(6) For every living creature, plant or animal, no matter how low in the scale of development it may be, there is a zone of humid-temperatures in which the life functions of metabolism, assimilation, transpiration, growth and reproduction are at their greatest efficiency. This applies to every cell and organ of every creature and to every function of the organism. By greatest efficiency we do not necessarily mean capability to do the greatest amount of work, but rather the capability to do the greatest amount of accurate, dependable work with the least exhaustion, wear and tear. This zone of temperature and relative humidity is what we used to call the optimum, but was renamed the practicotatum by the writer. The practicotatum for man is a zone, more or less elliptical in form if charted on paper, having approximately as its ultimate boundaries 32 and 55 per cent humidity and 55° and 70°F. temperature. This zone was denominated by Rosenau as the comfort zone, for within it we are the least conscious of the existence of air conditions and

feel the greatest sensation of personal comfort.

(7) The factory, school, hospital, office building, church or auditorium equipped with modern air-conditioning apparatus that will maintain throughout the year a fixed condition within this human practicotatum will, needless to say, maintain the conditions most favorable to health, happiness, contentment and human efficiency. With proper measures for reduction of gases and dusts such conditions are almost ideal. It is no longer an imaginary condition, but an actual reality, and so accurate that by thermostatic and hygrostatic control temperature is held within two degrees and humidity within four per cent by both the leading systems of air-conditioning.

(8) Surrounding the practicotatum is a more or less large thermopractic zone, which in the case of man we may call the zone of practical working conditions, and for other living creatures we may call the zone of effective humid-temperatures. Broadly speaking no man should be expected to work, except for very short periods under factory conditions, at humid-temperatures outside of this zone, which may be roughly described as bounded by 36° and 90°F. and 2 per cent and 85 per cent humidity, with a diagonal axis running from 43° F. and 100 per cent humidity to 78°F. and 0 per cent humidity, elliptical in form with the short axis perpendicular at 63°F. and 43.5 per cent humidity. The curve of the ellipse is tangent upon but does not cross the line of the wet bulb of 70° at 30 inches pressure.

(9) Hospital patients should be kept by all means within this zone, for it is the zone of bodily activity, and how can we expect the healing processes to take place when the air conditions inhibit them? The nearer the patient can be kept to the practicotatum the better. Of course in this connection we must remember that the disease organism also has its practicotatum and our patient must be held under thermopractic conditions least effective for the disease and most effective for the recuperative processes in the patient's own body.

"Climate Has Been Conquered"

(10) Any condition of weather can be brought into any factory or hospital. Geography and climate have been conquered. If you want to do something which has always in the past been associated with a certain place or climate, you can now do it at home by installing artificial weather. There is no reason for sending a patient to a distant climate, which may be exhausting and enervating and far out of the bounds of effective conditions, when in the hospital in his home town near friends and the source of funds, he can be

kept in a cheerier mood at the most favorable conditions for the curing of his malady.

(11) Surrounding the zone of practical working conditions are subzones of debilitation and discomfort, of sluggishness, of pain and intense suffering (either from cold, heat, dryness, or moisture). Work is often done under these conditions, but it cannot be satisfactorily done, and the health of the laborer is soon impaired. Any condition which causes a feeling of chill, a numbing, a thirsty or parched condition, excessive perspiration, stifling, depressing fatigue, frequent need of rest, quickened or sluggish pulse or fever is dangerous to health, and lies within the boundaries of these subzones of debilitation, sluggishness and pain. Under no circumstances should hospital patients be kept under such air conditions.

The Anesthetic Zone

(12) Surrounding these subzones is the anesthetic zone or zone of unconsciousness, comprising all those conditions which induce sleep and unconsciousness preceding death. In the lower animals true anesthesia is displayed by the phenomena known as hibernation and aestivation which the writer has shown are one and the same phenomenon. For instance in dry countries, an insect may be in the anesthetic zone throughout summer, fall, winter, and in fact through several years with extremes of hot and cold weather, and will only awaken when the necessary humidity brings the air conditions within the zone of effective humid-temperatures. With man the anesthetic zone is very dangerous but we see it in people who fall asleep in the cold (rhiganesthesia), or who collapse from thermoplegia or heat stroke, and are while unconscious in a state of thermanesthesia. The human death zone (olethric zone) is very close to the anesthetic zone and its position depends largely upon the individual's physical condition.

(13) A temperature which is thermopractic at one humidity (that is 90°F. at 35 per cent humidity, may be thermonochelic causing sluggishness—at another humidity (90°F. at 65 per cent humidity); thermalgesic causing pain and fever at another humidity, (90°F. at 80 per cent humidity), and thermanesthetic, thermoplegic or thermolethric at a still different humidity (witness strokes and death at 90°F. and 100 per cent humidity).

(14) Although 90°F. and 100 per cent humidity brings about stroke and death, such a condition at 5 per cent humidity is not likely below 115°F.

(15) Although 70 per cent humidity is regarded as the best for weaving we must not think

that any temperature can be withstood at this humidity, for stroke and death may occur at 70 per cent above 105°; at 100° only cautious work is possible, because of rapid rise in body temperature; at 90° hard work is impossible; and in fact operatives should not be required to work above 82°; at 79° one feels discomfort and perspiration; but below 75° there is little or no discomfort in ordinary clothing; at 65° to 70° the best weaving is done in England; at 60° English weavers are satisfied; at 50° to 57° best work is done in New England; below 37° a sense of chilliness is experienced; below 28° one is sluggish; below 22° pain and frost bite are experienced; and below 10° there is danger of freezing to death unless very active, warmly dressed, and well nourished.

There is no doubt but that any industry adopting this modern theory of air-conditioning and installing an appropriate system therefor will greatly increase the efficiency and health of its workers, as well as better the quality of its products. Bread made by the new system of air-conditioning is superior in quality, and the same may be said of macaroni, candies, chemicals and drugs, rubber, and chewing gum, and multitudes of other products. Needless to say foods made under sanitary air conditions will be superior also from the sanitary standpoint.

It is not the province of this article to speak of the relative merits of the commercial systems in use, but the purchaser can expect satisfaction if he receives a guarantee that the system when installed will meet his specifications. He should specify an air-conditioning system that will en-

able him to control both humidity and temperature automatically in any room or throughout the plant at any fixed combination he shall desire; that the system shall be so flexible that the conditions in any room may be set at will by adjusting the automatic controls; that he may maintain different air conditions in different departments at the same time. In the rainy season the humidity is too high outside

and the dehumidifier must rectify this in the plant. In the dry season the humidifier will carry the burden. In the cold weather the heating system, and in the hot weather the refrigerating system will function. In other words the true air-conditioning system has at least four functions—heating, cooling, drying, moistening and to these may be added air-washing and ventilating.

Just what combinations of temperature and humidity are necessary in any department to obtain the best quality and greatest quantity of this quality of product, with the greatest efficiency of machinery and at the least strain upon the physique of the laborer, is a question which must be determined by independent investigation in each department of a plant. In the human factor alone we must consider the racial reactions of the employes, the previous environment, the health and the clothing of the individuals. Just as by psychological tests we

Some possibilities in controlling air conditions which have scarcely been dreamed of by the hospital executive are outlined by Dr. Pierce in the accompanying article. Just how practical they may be the near future will undoubtedly tell. In certain industries, the application of these principles have made working conditions not only tolerable but even pleasant. The author of this manuscript sees them as revolutionizing hospital air-conditioning practice.

"Any condition of weather can be brought into the hospital," says Dr. Pierce. "Geography and climate have been conquered. If you want to do something which has always in the past been associated with a certain place or climate, you can now do it at home by installing artificial weather. There is no reason for sending a patient to a distant climate which may be exhausting and enervating and far out of the bounds of effective conditions, when in the hospital in his home town near friends and the source of funds he can be kept in a cheerier mood at the most favorable conditions for curing his malady.

"Any condition which causes a feeling of chill, a benumbing, a thirsty or parched condition, excessive perspiration, stifling, depressing fatigue, frequent need of rest, quickened or sluggish pulse or fever is dangerous to the health and lies within the boundaries of the subzones of debilitation, sluggishness and pain. Under no circumstances should hospital patients be kept under such air conditions."

ascertain the relative fitness of applicants for particular tasks, by thermo-practice tests we must ascertain under what conditions the acceptable candidates are most fit and must endeavor to place them at their tasks under such conditions as to derive the greatest amount of efficiency from them.

Finally, without in any way desiring to express an affirmative opinion for or against any present-day system of hospital practice, the writer desires to set to thinking upon certain definite points those who are in better position to know.

(1) Presuming that fresh air is desirable, especially for patients with bronchial and lung diseases, is it true that any kind of fresh air is equally efficient? Arguing merely from personal behavior, the writer feels that raw cold air, supercharged with moisture, and hot stifling air, similarly charged, and intensely hot still dry air may be so depressing that the tissues have no chance to mend. Would not fresh vitalized air of moderate temperature and low humidity be the most desirable in the case of such diseases?

(2) Is it not possible that in fever cases a rapid change of air to give fresh oxygen and remove fever affluvia, maintained at a moderate moist temperature would give better results than uncontrolled air? Or at least, is it not possible that by controlling the air you could find conditions superior to the average uncontrolled hospital conditions?

(3) Would not dehumidification be of great aid in moist weather in the treatment of rheumatic and asthmatic patients?

(4) Is it possible that in diseases with alternating chill and fever the patient's condition might be ameliorated by a control in the opposite direction of the room conditions?

(5) In dealing with diseases characteristic of winter time would not fresh air conditions of summer time be of tremendous aid in hastening control of the diseases?

(6) Does not a patient recuperate faster when the air conditions are most pleasant?

(7) Would the obnoxious hospital disinfectant gases be as necessary if the air was constantly being changed and fresh washed air of suitable temperature replacing it? Would not the absence of these odors be beneficial in the cure of many patients with hypersusceptibility of gases?

LEAGUE TO CONDUCT EPIDEMIOLOGICAL INTELLIGENCE SERVICE

The International Health Board of the Rockefeller Foundation has entered into a cooperative arrangement with the Health Organization of the League of Nations whereby the board will provide a sum not to exceed \$32,840 a year for a period of five years for the purpose of maintaining an international epidemiological intelligence service. The board will also provide a sum not to exceed \$60,080 a year for three years to put into effect a scheme for the international exchange of public health personnel to be conducted under the auspices of the Health Organization of the League.

The Health Organization of the League of Nations was created in September, 1921. Its principal function at

present is to conduct an international epidemiological information service and in general to promote international cooperation in the control of epidemic diseases. Incidentally it will advise the League in matters affecting health and cooperate with the International Labor Organization in promoting industrial hygiene.

Since its establishment the intelligence service has kept all governments informed as to the status of epidemics of typhus, intermittent fever and cholera, which have been sweeping westward from the famine-stricken regions of Russia. Negotiations among European governments looking to the adoption of sanitary conventions for the control of epidemic diseases have been initiated by the Health Organization and much progress already made. It has also undertaken to promote the international standardization of vaccines and serums.

For the first time in the history of the world there is an agency for taking steps to control epidemics before they get out of hand. The intelligence service of the League of Nations is of vital importance to the people of all countries. It is expected that by the end of the five-year period for which funds have been provided by the International Health Board the epidemiological intelligence service will have become so efficient and valuable that the various national governments will regard it as indispensable and provide funds for its further maintenance.

The exchange of public health personnel is expected to reinforce the other activities of the Health Organization by promoting mutual acquaintance, understanding and good-will on which effective international cooperation must be based. Interchange of health officials will be arranged not only for observation but for definite periods of service which will result in actual exchange of experience. The proposed system of exchanges will be put into effect first in Europe and may be extended as opportunity offers to other countries throughout the world.

DR. BIGELOW NAMED DIRECTOR OF CORNELL CLINIC

Dr. George H. Bigelow has assumed the position of director of the Cornell Clinic, the teaching clinic of Cornell University Medical College. Mr. C. F. Neergaard, who has been in charge of the clinic during the period of its reorganization from the old type of dispensary to a pay clinic, is now returning to business activities, although he will continue his general interest in the Cornell Clinic and in other hospital and dispensary affairs in New York.

Dr. Bigelow is a graduate of Harvard College and of the Harvard medical school; he served an internship in the Massachusetts General Hospital, was in the medical corps of the army during the war in this country and abroad, served as acting state epidemiologist of the Massachusetts state department of health, and was a member of the staff of the department of preventive medicine and hygiene of the Harvard medical school. During the past year, he has organized the department of industrial health of Antioch College, Ohio.

SUPERINTENDENT SHOULD BE IN COMMAND

A private hospital had for its chief surgeon a man that would often countermand many of the teachings of the superintendent of nurses with the result that the poor nurses did not know which teaching method to follow. On account of this situation the superintendent, who was very capable and efficient, left the institution. The same condition continued until the hospital had to be closed.

McLAUGHLIN HALL—A MEMORIAL TO NURSES

BY STEWART HAMILTON, M.D., SUPERINTENDENT, HARPER HOSPITAL, DETROIT, MICH.

MCLAUGHLIN Hall, which is said to be the most beautiful and complete nurses' home in the country, was given to Harper Hospital by Detroit's public spirited and philanthropic mayor, James Couzens, who is a member of the board of trustees of the hospital. The home is a memorial to the nurses of the Farrand Training School who served during the World War.

Sod was turned for the building March 9, 1921 by Miss Emily A. McLaughlin, principal of the Farrand Training School, who was chief nurse of Base Hospital No. 17 in France. Within less than a year from that date it was ready for occupancy. The formal opening was on May 10 which is the occasion of the reception given each year to the graduating class by the board of trustees of Harper Hospital. It was informally opened to the public May 12, National Hospital Day.

frontage of 145 feet and a depth of 116 feet. It is entirely fireproof, its construction being of concrete, steel and brick.

Floors are all concrete; the halls, battleship linoleum, and bathrooms are of terrazzo finish. There are two stairways in the rear of each wing and one automatic elevator. The stairways are designed as fire escapes and are of concrete and steel with treads of terrazzo finish. They are separated from the halls on each floor by steel doors framing wire glass.

The exterior of the home is enclosed by a balustrade on the open side of the court which one reaches by a short flight of steps. The porch is Italian loggia in design and presents an attractive entrance. In the rear of the building running the entire length of the living room is a wide screened porch from which one looks down upon



McLaughlin Hall is one of the nation's most beautiful nurses' residences.

The building is located on a large plot of ground south of the hospital, with which it is connected by a tunnel. It is an imposing structure six stories high and it is so built that another story may be added. It has a capacity for 285 nurses. The architecture is of Italian Renaissance type. The outside is of brick, trimmed with limestone. It is dignified in design and its simplicity is relieved and given added color by several wrought iron balconies, as well as by pattern brick work in the frieze-like top story.

The building is in the shape of an inverted U surrounding a seventy-five foot court and has a

sunken gardens with walks of broken flagstones; farther on are the nurses' tennis courts rarely empty.

In another year landscape gardening will have added the softening touch of plant and shrub. The sunken gardens are of formal design to correspond with the architecture of the building and are enclosed in evergreens which are to be used as a ground cover in the form of a hedge. The same plan will be used for the front of the building.

This beautiful landscape gardening is a gift from the firm of Travis Brothers, one of the best

known landscape gardening companies in Michigan. The trees and shrubs are the gift of Greening Brothers from their excellent nurseries at Monroe, Mich.

Reception Hall Richly Furnished

Upon entering the first floor of the building from the front, one is admitted to a reception hall twenty-five feet square with a floor of large square tiles alternating gray and white. The character of the decoration is known as "Adam." All openings from this room are arched French doors and arched windows; the central openings to right and left are mirrors. The walls are in several shades of soft gray stippled over one another. The wood work is ivory and the ceiling is in low plaster relief decoration.

This room is furnished in walnut, with paneled walls. Small tables and chairs upholstered in blue are disposed around the room. Two large settees upholstered in rose are placed in front of the mirrored central openings. The carpet is of soft taupe and covers the floors of other rooms opening off the reception hall. An electrolier of brass in antique design hangs from the center of the ceiling and wall clusters with crystal trimmings from side walls.

The library opening off the living room carries the same color scheme and the same style of furniture with the addition of built-in bookcases on either side of the connecting doorway. The most attractive feature of the room is the antique ornamental plaster design of the slightly arched ceiling. A beautiful French mirror in a gold frame hangs in charming relief against the dark walnut finish of the walls.

At the right of the reception hall is a small reception room, beautiful in soft grays and ivory tints, and furnished with varying shades of green harmonizing with the colorings in the adjoining rooms. Silver electroliers and wall clusters complete its decoration. The unity of the color scheme is preserved by the taupe carpet, the soft pongee curtains and the rich chintz drapes throughout the four rooms dedicated to the social pleasure of the pupil nurses.

A business office for the desk of the house mother, containing telephone switchboard, mail boxes and electric light switches, opens off the main reception hall. There are buzzers in every bedroom by which the telephone operator calls its occupant to the telephones which are on every stair landing in the building.

The south wing contains a large beautifully furnished living room for the exclusive use of the supervisors of the hospital. It is furnished in dark wicker; upholstering and draperies are in

fuchsia shades. At Christmas time the training school presented the faculty and supervisors with a silver tea and coffee percolator with creamer and sugar bowl for use in this room.

One reaches the living room which is directly beyond the reception hall through three sets of French doors. This beautiful room is forty feet long and 20 feet wide and opens upon a wide porch running its entire length by means of five French windows. At one end of the room is a large fireplace in which repose a pair of ancient andirons, the gift of Mrs. Barbara H. Bartlett, professor of public health nursing at the University of Michigan. At the opposite end of the room, a large double door leads to the library. Both the living room and the library are English in their decorative scheme, having a pilaster and wide panel treatment in gum wood, walnut finish, from floor to ceiling. The ceiling has a border of ornamental plaster in keeping with the panelling of the room. The fireplace and baseboards are finished in green Verde antique marble.

Bronze electroliers with wall clusters to match them, three floor lamps and two reading lamps of different designs complete the lighting which radiates through soft orange and tan shades.

Two long walnut tables for the living room and one for the library, with numerous chairs of walnut upholstered in blue and in various tapestry designs, are arranged so as to give the effect of several smaller rooms. Two lounges upholstered in blue and another in harmonious tapestry design complete the demand for comfort. The bright rich tones of the chintz in the curtains are carried over into the room in bits of bright pottery. In one end of the room there is a spacious walnut desk and in the other a Steinway baby grand piano, the Christmas gift of the Harper Hospital staff physicians to the training school.

The Principal's Quarters

The suite of rooms provided for the principal of the training school leaves nothing to be desired from the standpoint of beauty and comfort. One enters both the bedroom and the sitting room from the main hall. The rooms have a connecting hallway on one side of which is the bathroom and on the other built-in cupboards. An immense closet opens off the bedroom.

The bedroom is furnished in the lighter shades of walnut of colonial design and has a four poster bed with an old fashioned high boy, and a low dressing table and a rocker of the same design. Another chair and a plain screen with coverings of blue shot with copper lighten the effect. Copper-colored hangings tinged with blue drape the windows. The dominating color notes



The imposing entrance to McLaughlin Hall is Italian loggia in design.

of the room, including walls and woodwork, are all shades of the sepia family relieved by blues and copper.

In the sitting room the necessary contrast is found in the black wrought iron andirons of the fireplace and the candelabra of the mantle piece. A walnut bookcase occupies an inset in the wall next the fireplace and across from it is a low desk of rare design. A small settee and the window drapes are of Indian print. A tea wagon and a gateleg table as well as a small table, a floor lamp and two upholstered chairs complete the furniture. Some rare bits of pottery and pictures and a marble bust of Joan de Arc brought from France with the return of Base Hospital Unit 17 give to this exquisite room its final touch of individuality.

The remainder of the south wing contains eleven bedrooms for graduate nurses employed in the hospital in such positions as the admitting office, social service and out-patient departments, and for their use there are two showers, two tubs and eight wash basins as well as a kitchenette. A room with private bath is for the use of the house mother.

School Rooms and Laboratory

The entire north wing of the first floor is given over to the educational interests of the training school and emphasizes strongly the thought that has taken root in the minds of advanced hospital officials today, namely: that training schools for nurses are schools of nursing and need proper school equipment.

One large demonstration and lecture room seats

sixty-five pupils and has room for six beds, one of which is continuously occupied by the famous Chase doll. It is a workroom and has closets and cabinets which contain the necessary articles for the successful demonstration of practical nursing procedure. It also contains a stationary washstand with hot and cold water, an ample blackboard and student chairs with wide arms for convenience in writing class and lecture notes. In place of the old gas plates upon which we have for years heated the water for demonstrations in the giving of fomentations there is provided an electric plate which may be attached to various plugs in different parts of the room.

A smaller classroom is equipped with special conveniences for the teaching of anatomy. It seats thirty persons comfortably and contains skeletons, models and anatomical charts. Still another classroom seats forty students and is used for a study room, classroom or examination room as needed.

A laboratory in which there is arrangement for fourteen Bunsen burners, any number of microscope lamps and sinks, large and small, furnishes the needed arrangement for teaching solutions in materia medica, microscopic work in bacteriology and test tube demonstrations in the examination of urine.

One of the most gratifying features of these classrooms is the overhead duplex-o-lite lighting which is uniform throughout the room and casts no shadows. Two of the classrooms contain stationary wash stands, desks for the instructors and all of them have the necessary blackboards.

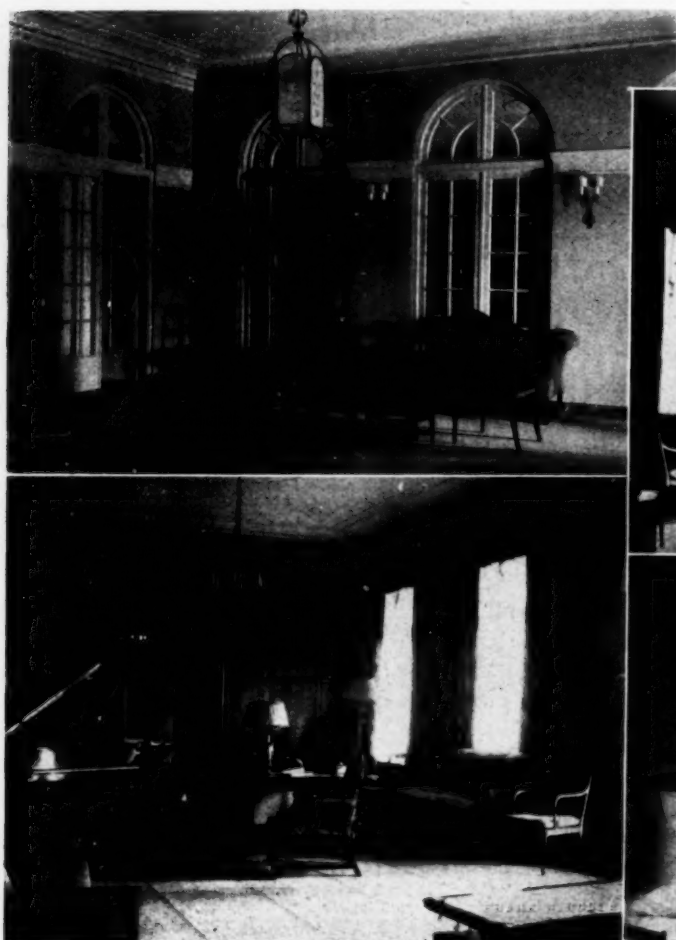
Connected with the teaching wing is a lavatory

containing three wash basins and three toilets. In order to preserve the decorative scheme of the first floor, all doors leading to the classrooms are of French design. These are well as the windows have draperies of silk pongee; the walls are putty color, and the concrete floors are painted soft browns.

There are two full-time instructors and each has an office. Each office contains the necessary files, bookcases, typewriter and chairs. The furniture is dark oak; the floors are carpeted to har-

and 350 folding chairs. This room is for the use of the student nurses' entertainment at any time of day. It lends itself equally to dancing or a minstrel show as well as to dignified lecture and religious service. The Alumnae Association of the Farrand Training School has the free use of the room for meetings and for social functions, such as banquets, receptions and lectures. There are cloakrooms, a kitchen and serving room which furnish every convenience for entertainment.

Laundry tubs have been provided for the use of the student nurses. A unique device in connection with the electric irons is the red light

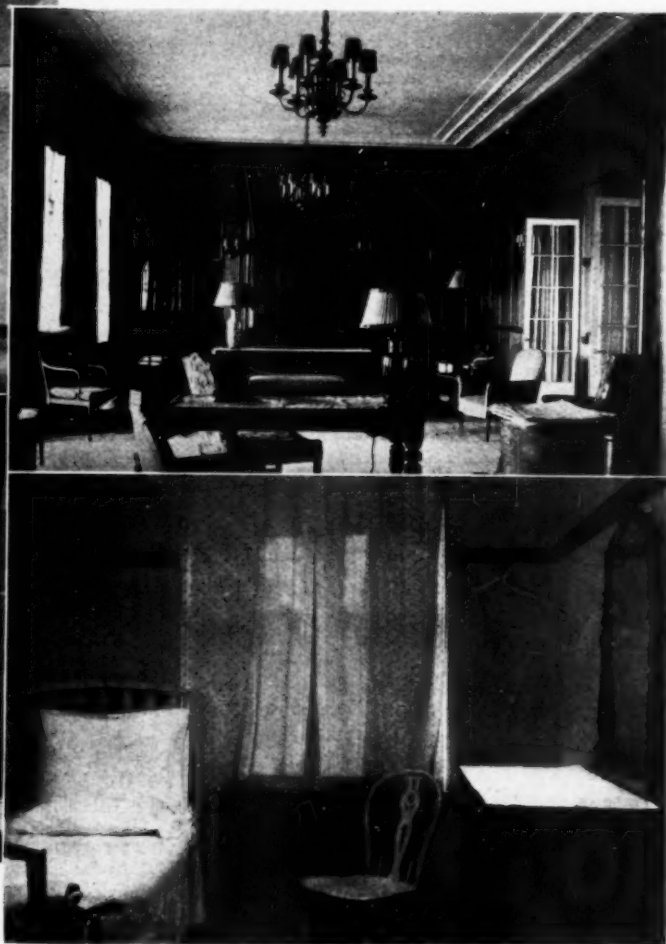


Views of main reception hall (above) and living room.

monize with the walls and the drapes are of silk pongee.

A reference room with a capacity for one thousand volumes completes the plan of the educational wing of the home. This room is furnished with a library table, a dictionary and six straight chairs.

The auditorium and gymnasium are in the basement and thrown together will seat 350 persons. The auditorium has an outside entrance directly upon the sunken gardens. It contains a rolling stage which may be placed wherever desired and may also disappear altogether through an opening in the baseboard. There is a piano



Another view of living room (above) and a nurse's bedroom.

which burns like a bright button on the wall opposite the one using the iron and remains as long as the electricity is turned on. Linen and sewing rooms for the use of the student nurses together with large trunk and storage rooms as well as lavatories and rest rooms for the maids complete the basement.

The floors above the first all are exact duplicates of one another with the exception of the second which contains an infirmary for sick nurses. This may be entirely shut off from the

other part of the floor and contains a kitchenette for complete tray service as well as its own bath and lavatory.

Each floor contains twenty-eight single and eleven double rooms. The single rooms occupy the wings and the double rooms run across the rear of the house. The northeast and southeast corners have suites of two large rooms with a connecting bath for use of two supervisors.

The general finish of all walls is either putty color or a very soft grey with woodwork stained walnut. Windows of all bedrooms are forty-six inches wide including the casings. All rooms have a duplex-o-lite overhead light and a base-board plug for reading lamp. A plate rail runs around each room and obviates the necessity of using tacks and nails in the wall.

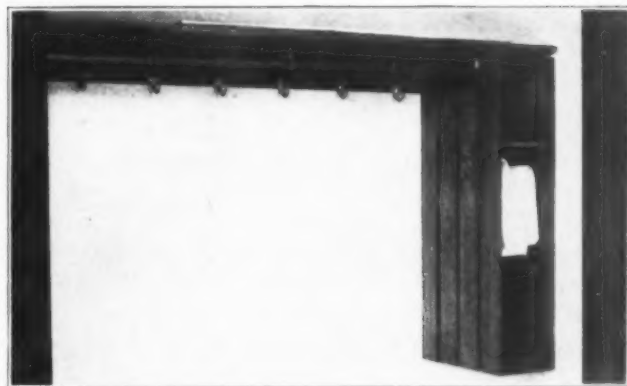
Two telephones and a kitchenette assist in making life comfortable for the occupants of each floor. The bathrooms and lavatories are in each wing, and for the entire floor there are four baths, four showers, two dental bowls and sixteen wash-bowls (exclusive of those which are in each of the double rooms.)

The Nurses' Sleeping Quarters

The double rooms each have two closets, two beds, a desk table and desk chair, and two rockers as well as two large rugs of mixed colors.

All the single rooms have a built-in wardrobe with a towel and tooth brush holder designed by Miss McLaughlin, of which there is an accompanying illustration. There is a desk table, desk chair, a windsor rocker and metal beds finished in cream or mahogany. Each room is given contrast by its deep cream-colored chairs trimmed in dark browns and blues and its mahogany bed, desk and bureau. Where the bed is cream in color the rest of the furniture is mahogany finish. Large rugs in grays, browns or taupes cover the floor. The window curtains are of marquisette, the overdrapes express the choice of the occupant and represent a riot of color.

Each supervisor's room contains a four poster mahogany bed with box springs. There is a bureau of colonial design to match, a desk table with desk chair, a windsor rocker, an upholstered wicker chair and a small bedside table. The floors are almost entirely covered by one large rug in neutral colors of browns, taupes or grays. The hangings were chosen by the supervisors from a number of samples furnished by the hospital, and the color plan of each room is their choice. Walls, woodwork and lighting are the same as in the pupil nurses' rooms. Each supervisor's room has two windows and large built-in wardrobe closets.



The wardrobe closet, showing buzzer, and towel and tooth-brush rack devised by Miss McLaughlin.

Aside from the arrangements for the principal and the floor supervisors as described, the assistant principal has a suite of two rooms and a bath and the senior instructor has the same.

From the moment the sod was turned for McLaughlin Hall an intense interest, almost personal, has been manifested by the architect, Mr. Albert Kahn, and by all those whom he chose for its construction. An incident of this was expressed in the presentation of an American flag to Miss Emily A. McLaughlin, principal of the Farrand Training School, who was the chief nurse of Base Hospital No. 17, by the workmen on the building to commemorate the fourth anniversary of the departure of the nurses from Harper Hospital for France. Almost the entire personnel of Base Hospital No. 17 were Harper Hospital physicians and nurses.

Mr. Kahn gave his personal supervision to the finishing and decorating of the reception and living rooms. Aside from this, instead of the services of a decorator, the selection of furnishings and the details of this beautifully appointed home have been in the hands of the matron, Mrs. Bessie Bright. Mrs. Bright's artistic training and gifts as well as her wide experience in hospital life have made it possible for her to combine beauty, comfort and utility so that an atmosphere of restfulness prevades the entire home.

This is the first memorial that has been dedicated to nurses of the World War but we trust it will not be the last.

Many lives and much property are lost every year because of accidents due to venereal diseases, says the U. S. Public Health Service. So great in fact are these losses that the National Safety Council has issued a bulletin on them. For instance, four serious recent railway wrecks were traced to employes who failed because they were suffering from paresis, which is a form of syphilis.

Slavery is but half abolished, emancipation but half completed, while millions of freemen with votes in their hands are left without education.—Robert Charles Winthrop.

WHAT THE SMALL HOSPITALS PAY THEIR SUPERINTENDENTS

BY JOSEPH J. WEBER, MANAGING EDITOR, THE MODERN HOSPITAL, CHICAGO.

APPROXIMATELY \$150 is the average amount of the monthly salary check handed the men and women—mostly women—who superintend the hospitals of less than 100 beds throughout the United States. To this must be added an additional \$45, the average amount which their maintenance costs the hospitals. In other words, the average monthly salary of the superintendents of our smaller hospitals is about \$200, according to statistics compiled by THE MODERN HOSPITAL, based on data gathered from hospitals the country over.

In order to obtain authentic, broadly representative information on this subject, questionnaires were mailed to 900 hospitals having a capacity of less than 100 beds, selected from the various states in the ratio which the population of each state bears to the population of the United States. The response was most gratifying; 464 hospitals or fifty-two per cent of the total sent the data requested.

In order to analyze and compare the salaries received by these superintendents more readily the hospitals in the list were placed in four classes: 1 to 24 beds; 25 to 49 beds; 50 to 74 beds; 75 to 99 beds.

76 Per Cent Head Training School

Those familiar with the hospital field know, of course, that a large majority of the smaller hospitals are superintended by women. It is therefore interesting to observe that 398, or 86 per cent, of the 464 hospitals under consideration have women superintendents. Their salaries* range from an average of \$169.93 for hospitals with fewer than 25 beds to an average of \$203.47 for hospitals in the 75 to 99 bed group. Two women superintendents, one the superintendent of a 40 bed Methodist hospital located in a small town in the middle west, the other the superintendent of a 30 bed private hospital in one of the largest mid-western cities, receive salaries of \$300 and \$360 respectively. One superintendent of a 75 bed hospital receives as little as \$75 a month.

Of the 464 hospitals 417, or 90 per cent, conduct nurses' training schools. In all but 111, or 24 per cent, of these hospitals the superintendent also acts as the head of the training school. The increased work and responsibility

this additional function involves do not, however, seem to play any marked part in fixing the superintendent's salary, for an examination of the appended list will show that often the superintendent of a hospital who does not act as the head of its training school receives a higher salary than the superintendent of a hospital of the same size who does stand at the head of its school.

Men Command Higher Salaries

Of the sixty-six men superintendents, seventeen serve hospitals in the 25 to 49 bed group, twenty-eight in the 50 to 74 bed group and twenty in the 75 to 99 bed group. Their average salaries are higher than the salaries of the women superintendents in the same groups. In the 25 to 49 bed group, their average salary is \$39 higher; in the 50 to 74 bed group, \$67 higher; and in the 75 to 99 bed group, \$96 higher. The highest salary paid a man superintendent by the hospitals listed is \$458, plus maintenance. He is the superintendent of an 80 bed hospital in the east. The lowest salary is \$100. Three or four receive \$125 a month.

The data collected show that the superintendents of 303 hospitals, or 65 per cent of the hospitals listed, have had increases in their salaries, mostly during the past two years. They range from \$5 to \$141 a month, with an average of \$28 a month. On an average salary of \$195, this represents about a 14 per cent increase. Of the 464 superintendents reporting only two had salary decreases; the amounts were \$50 and \$27 a month.

A comparison of the salaries received by superintendents of nurses with the salaries received by the heads of other departments is interesting. In the March issue of THE MODERN HOSPITAL it was pointed out that the average salary of the superintendent of nurses of 228 hospitals of all sizes was \$1,868 a year, exclusive of quarters, subsistence and laundry. This makes an interesting comparison with the almost similar figure of \$1,794.12, the average salary of the superintendents of the hospitals of less than 100 beds. Previous salary studies (May and June, 1922) show that the average monetary salary of the superintendent of the hospitals of less than 100 beds is \$590 more than the average salary of the dietitians, and \$266 more than the average salary of the social workers. It will be apparent,

*Unless otherwise stated, when the term salary is used in this article, it includes not only the monetary salary but also the estimated monetary equivalent of maintenance.

of course, that the individual salaries of both dietitians and social workers, especially those connected with the larger hospitals, are often equal to or in excess of the salaries of many of the superintendents of the smaller hospitals.

No Minimum Standard Recognized

The results of our studies of the salaries of superintendents in general, of the superintendents of small hospitals, of the superintendents of nurses, of dietitians and of social workers, give us no evidence of the recognition of a minimum standard for the salaries of superintendents and heads of departments of hospitals of various capacity and character of service. Whether the establishment of such standards, subject to revision from time to time as the cost of living fluctuates, is practicable is of course a question. Its consideration, however, lies beyond the scope of this article. Might it not be well for the national organizations representing these groups to give the subject more consideration than they have hitherto? Such a service would be immensely valuable to boards of trustees and others in whose hands in the aggregate lie the employment and salary adjustment of no small army of workers.

The tabulations on which the conclusions of this article are based are as follows:

DETAILED INFORMATION REGARDING SALARIES PAID SUPERINTENDENTS OF 464 HOSPITALS HAVING LESS THAN 100 BEDS

1 to 24 Bed Group

Thirteen hospitals, or 2½ per cent of the 464 hospitals under consideration.

Average monetary salary	\$120.83
Average maintenance	49.10
Number of women superintendents	12
Number of men superintendents	1
Average salary of women superintendents	122.72
Salary of man superintendent	100.00
Date of first increase	1919
Date of last increase	Nov. 1921
Average increase	21.00
Smallest increase	15.00
Largest increase	50.00
Number with school of nursing	10
Number without schools of nursing	3
Number in which superintendent acts as head of training school	9

25 to 49 Bed Group

One hundred and forty hospitals, or 32¼ per cent of 464 hospital under consideration.

Average monetary salary	\$140.53
Average maintenance	41.49
Number of women superintendents	123
Number of men superintendents	17
Average salary of women superintendents	136.00
Average salary of men superintendents	175.00
Date of first increase	1918
Date of last increase	June, 1922
Average increase	25.00
Smallest increase	5.00
Largest increase	75.00
Decrease (1)	50.00
Number with schools of nursing	114
Number without schools of nursing	26
Number in which superintendent is head of training school	96

50 to 74 Bed Group

Two hundred and fifteen hospitals, or 46 per cent of the 464 hospitals under consideration.

Average monetary salary	\$157.83
Average maintenance	45.00
Number of women superintendents	187
Number of men superintendents	28
Average salary of women superintendents	149.00
Average salary of men superintendents	216.00
Date of first increase	1918
Date of last increase	May, 1922
Average increase	28.00
Smallest increase	5.00
Largest increase	141.00
Number with schools of nursing	199
Number without schools of nursing	16
Number in which superintendent is head of training school	140

75 to 99 Bed Group

Ninety-seven hospitals or 20 per cent of the 464 hospitals under consideration.

Average monetary salary	\$178.87
Average maintenance	44.47
Number of women superintendents	77
Number of men superintendents	20
Average salary of women superintendents	159.00
Average salary of men superintendents	255.00
Date of first increase	June, 1917
Date of last increase	May, 1922
Average increase	33.00
Smallest increase	10.00
Largest increase	100.00
Decrease (1)	27.00
Number with schools of nursing	94
Number without school of nursing	3
Number in which superintendent is head of training school	61

SALARIES OF SUPERINTENDENTS OF 464 HOSPITALS HAVING LESS THAN 100 BEDS

1 to 24 Bed Group

No. of Beds	Sex of Supt.	Monetary Salary	Equivalent of Maintenance	Last Increase	Date of Last Increase
15	F	\$175.00	\$40.00	\$50.00	Oct., 1920
*16	M	100.00	75.00		
20	F	150.00	40.00	25.00	June, 1921
†20	F	125.00		15.00	Oct., 1921
20	F	100.00	50.00		
20	F	100.00	50.00	25.00	June, 1920
20	F	100.00	46.00	15.00	Jan., 1921
20	F	100.00	0		
21	F	125.00	50.00	25.00	Nov., 1921
22	F	100.00	25.00		
*24	F	150.00	65.00		
24	F	125.00	40.00	25.00	April, 1920
24	F	100.00	40.00		

25 to 49 Bed Group

25	F	125.00	40.00	25.00	Sept., 1920
25	F	125.00	18.00		
25	F	150.00		25.00	1919
25	F	100.00	26.00	15.00	1921
25	F	125.00	5.00		
25	F	100.00	40.00		
*25	F	150.00	60.00		
†25	M	125.00			
25	F	150.00	50.00	25.00	April, 1922
25	F	125.00	48.00	25.00	Nov., 1921
*25	F	125.00	25.00		
25	F	100.00	40.00		
25	F	115.00	45.00		
25	F	100.00	40.00		
*25	F	150.00		25.00	Feb., 1921
25	F	125.00	35.00		June, 1920
25	F	200.00	40.00	50.00	Feb., 1922
*25	F	125.00	17.75	25.00	Jan., 1920
25	F	150.00	40.00	25.00	June, 1921
25	F	125.00	50.00	25.00	Jan., 1921
26	F	140.00	95.00	15.00	Jan., 1920

A star (*) indicates the absence of a training school. A dagger (†) indicates that the superintendent is not the head of the training school. Where no star or dagger appears the hospital has a training school and the superintendent acts as its head.

(Continued on page 232.)

ORGANIZING THE MEDICAL SERVICE OF A STATE HOSPITAL

By A. L. BOWEN, FORMER SUPERINTENDENT OF CHARITIES, ILLINOIS DEPARTMENT OF PUBLIC WELFARE, SPRINGFIELD.

IN THE August issue of THE MODERN HOSPITAL an attempt was made to outline the necessary medical personnel of a state hospital. In this number will be described how such medical service may be organized to secure the best results.

If the state operates a group of mental hospitals, it should have a central psychiatric institute and hospital with laboratories equipped to do the more highly technical work that the various hospitals in the group may not be prepared to do. If the state has only one state hospital, it should be organized to serve the purposes of the central institute and hospital.

Institute is Research Center

This institute becomes the teaching and research center of the state. The psychiatric hospital in connection should be reserved for acute mental and nervous cases; voluntary admissions, so far as possible. Physicians of the various medical staffs may be summoned to this institute in groups for periods of instruction each year. Members of the staff of the institute or its director may visit the various hospitals at intervals to check up on the work of local medical officers and to lecture both to the medical and nursing service. To all such lectures and clinics the practitioners in the community should always be invited.

The training school for psychiatric nurses, and the training school for psychiatric social workers may be conducted at this central point from which also may be directed mental clinics and dispensaries in the civil communities throughout the state.

In other words this institute becomes the seat of inspiration, the center of research, learning and instruction, the maker of standards, the barometer of the service in the state and the recognized authority on mental and nervous diseases in both state and private practice.

Each hospital must be organized and equipped to make use of such a staff as was previously out-

"Institution life is a life of ruts and routine. Staff men themselves may determine that it shall be otherwise. Contact with each other in other than professional relations, contact with the profession in the community, contact with the people of the community through religious, social and welfare orders are all possible. Staff members are too prone to overlook their opportunities. The average medical staff degenerates because it is not properly organized and stimulated to intensity, to study, to research, to vision and imagination and to professional esprit de corps. Yet there is no place in medical practice where opportunities are greater or go to waste with such prodigality."

lined. Wards for the physically sick may be located anywhere in the institution, but a detached building is to be preferred; one just large enough to accommodate the patients who are suffering from acute physical illness. The infirm, ambulatory and convalescent do not belong in this department. The institution hospital should be a modern general hospital. It should have operating rooms, quarters for all manner of dispensary

service, dentistry, laboratories, morgue, classrooms for the local training schools for nurses, occupational therapists and attendants and an x-ray department; in short, everything that goes to make up a modern general hospital must be included. No state hospital can be complete without such a hospital service centered in a detached structure.

In every state hospital there are many aged, infirm, cripples and chronic sufferers of various types not needing bedside attention. For them special types of wards are very important. Detached buildings are to be desired but wards for them may be organized wherever there is plenty of sunlight, good ventilation, easy exit to the grounds and ample toilet and bathing facilities. Wards for convalescents are next to be considered. As soon as patients may be removed from the general hospital they should be taken into attractive quarters where the opportunities for speedy acquirement of strength are good. Special diet is as necessary here as in the hospital or in the infirmary.

Segregation of Tuberculous Patients

No longer may tuberculous patients be tolerated on the wards, scattered indiscriminately throughout the institution, yet this is the practice in many states. This type of patient is very undesirable in the main buildings if the institution happens to be congregate. Detached structures for tuberculous men and women are essential. These may be built without great expense and

should follow the lines of the established sanatoriums for civil patients. There are certain refinements in these buildings not required in the civil sanatorium. Bathing and toilet facilities must be more numerous, and must be nearer the beds. Provision must be made to keep the floors warm, because insane patients will elude nurses and get upon their feet. Flies are more of a problem in the "T B" wards of a state hospital than in a civil hospital; the tuberculous mental patient is much more of a menace than a civil patient because he seldom exercises any of the precautions which the sane patient will follow under direction. There must also be additional possibilities for isolation and separation of types and classes.

Dispensary Service is Desirable

Dispensary service in a state hospital is possible and will save medical men many steps. All inmates, not in special hospitals, convalescent wards or infirmaries may go to a central dispensary for whatever attention they may require. An attendant or nurse may accompany them or they may go in parties under the supervision of a paroled patient. Going to and from the dispensary is not a problem at all, though doubtless many administrators will look upon it as an insurmountable obstacle. The success of the open institution where it has been tried indicates that the dispensary service would be successful.

The reception service which includes all acute mental cases should be organized as near as possible to the hospital's surgical, laboratory, x-ray and dentistry services. Under this plan everything pertaining to the medical care and treatment of the population of the institution is centralized for the convenience and the inspiration of the medical men and the benefit of those needing attention. This plan gives every doctor his share in the medical service and removes from his duties routine matters which can be handled just as well by laymen.

For instance, as commonly organized, the state hospital assigns to each physician a group of wards over which he is supreme in practically all subjects. He visits his wards two or three times a day. These visits many times are perfunctory. I have seen a doctor rush into a ward, ask the charge nurse if there is anything needing his attention and dash out. Perhaps she told him that the radiator in the north dormitory is leaking or John Smith needs a new suit of underwear.

Physicians' time should not be consumed in this manner. Seventy-five per cent of the institution's inhabitants are chronic patients who seldom require a doctor. Some physicians must draw

this routine. They seldom have occasion to prescribe. They soon drift into a rut, neglect their reading, grow stale and finally become institutional parasites. One or two draw the active, attractive service but there is lacking in the prevailing organization any incentive for them to do progressive, up-to-date, medical work, because of so much deadening routine and degenerating influence.

Superintendent Need Not be a Doctor

Many states, perhaps all of them, are laboring under the false impression that a state hospital must have a physician as superintendent. This is a fallacy. The superintendency requires a man of executive capacity and administrative ability and experience. If he is also a physician, it is well, but the position does not in any manner demand that a physician fill it. The superintendent has little time to give to medicine. Business affairs consume all his energy. The medical side may safely be entrusted to a live, modern young man, trained and experienced liberally in general and special medicine. He should of course be developed in the field of nervous and mental diseases. To him should be given the responsibility for everything medical: nursing, nursing schools, social service, occupational therapy, recreation, amusement and pretty much all that contributes to the physical or mental welfare of patients.

No attendant person should be placed on a ward until he has undergone a course in training. Each institution should have a training school for attendants where each applicant, as he enters, is required to take it and pass a reasonable examination, after which he would be eligible to active employment with patients.

The training school for nurses must emphasize mental nursing but there is no reason why it should not graduate women qualified to take the state examination of registration.

If students lack the preliminary education when they enter the service, let the institution provide it, either in classes within the grounds or in the high school in the community nearby. Every state hospital needs a corps of registered nurses as the nucleus of its nursing and attendant service.

Occupational therapists and occupational aides must get their practical training in state hospitals; there is no other place that can give it. Theory may be acquired in special schools but the field work with mental patients may be had only in state hospitals. Every state hospital, therefore, should organize classes for this type of worker.

Daily it becomes more and more apparent that employment, however light or unimportant it may be, is vitally necessary to the welfare of mental

patients. The so-called untidy wards are without excuse for their existence. Patients who mill and fight, tear their clothing and engage in damaging and dangerous practices are perforce of their idleness compelled to do these things. Energy expended in this manner may just as well be directed into useful or at least innocent channels with a very great improvement in the physical being. To be abreast of the times and to give modern care to mental patients, a state hospital must be able to carry on occupational therapy on every ward and among all patients, who are neither sick nor otherwise incapacitated. Convalescents above all should have employment for mind and hand. The success of all these schools depends upon the medical staff which must furnish the teachers and the inspiration. The assignment of mental patients to occupation or employment, to recreation and special or habit training is a part of the duty of the medical service.

Every local staff should have its club for social and professional purposes. Institution life is a life of ruts and routine. The men themselves may determine that it shall be otherwise. Contact with each other in other than professional relations, contact with the profession in the community, contact with the people of the community through religious, social and welfare orders are all possible. Staff men are too prone to overlook their opportunities.

But primarily I believe that the average medical staff goes stale and degenerates because it is not properly organized and stimulated to intensity, to study, to research, to vision and imagination and to professional esprit de corps. Yet there is no place in medical practice where the opportunities are greater for all these things or go to waste with such prodigality.

A SUNNY HOSPITAL WARD



Wide World Photos.
An open-air ward at Lord Mayor Treloar Cripples' Hospital at Alton, England, where the curative powers of the sun's rays are being utilized.

TORNADO DAMAGES ARMY HOSPITAL

Roofs were torn off, windows smashed, beds hurled across the wards and other damage done on July 14 when the Fitzsimons General Hospital, a government institution near Denver, became the center of a small tornado. None of the patients was injured.

A terrific wind carried the roof off the main hospital building and dropped it 100 feet away. Roofs of seven other buildings were partially wrecked, hundreds of windows were broken, tennis courts were demolished, the Red Cross building was damaged and the electric and water systems were put out of operation by the brief storm. The beds occupied by several ex-soldier patients were said to have been blown across the wards, but in spite of the showers of glass and flying timbers, all patients escaped injury.

The damage was estimated at \$50,000. The storm was purely local in nature and aside from an unusually high temperature for six o'clock in the evening, nothing unusual in the weather conditions was noted.

ROCKEFELLER FOUNDATION AIDS HOSPITAL AND HEALTH WORK

Among the gifts of the Rockefeller Foundation during 1921 for hospital and health purposes, the following are enumerated in the president's report recently issued:

Pledged \$2,000,000 to Harvard for a school of health.

Continued the \$250,000 annual appropriation for Johns Hopkins school of hygiene and public health.

Contributed large sums to public health in Czechoslovakia, Brazil and the United States.

Promoted the cause of nurse's training in the United States and Europe.

Underwrote an experimental pay clinic at Cornell University medical school.

Opened the hospital and medical school at Peking, China, and assisted twenty-five other medical schools in that country.

Pledged \$1,000,000 for Columbia University medical department.

Contracted to appropriate \$3,500,000 for rebuilding the medical school and hospital of the Free University of Brussels.

Made surveys of medical schools in Japan, China, Philippines, Indo-China, Straits Settlements, Siam, India, Syria and Turkey.

Supplied American and British hospital and medical journals to 112 medical libraries on the European continent.

Supplemented the laboratory equipment and supplies of five medical schools in Europe.

Paid expenses of commissions from Great Britain, Serbia, and Brazil.

Provided 157 fellowships in hygiene, medicine, physics and chemistry to representatives of eighteen countries.

Continued a campaign against yellow fever in Mexico, Central and South America.

Conducted demonstrations in the control of malaria in ten states.

Cooperated in hookworm work in nineteen governmental areas.

Participated in rural health demonstrations in seventy-seven American countries and in Brazil.

Provided experts in medical education and public health for many parts of the world and rendered other services to governments and voluntary societies.

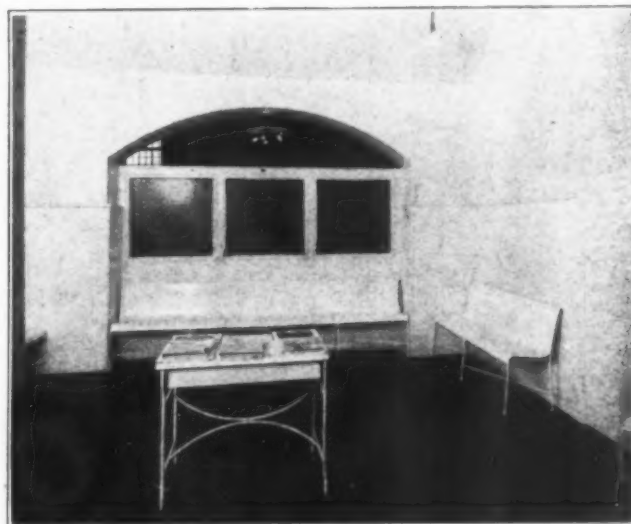
THE RADIOLOGICAL CLINIC OF THE PHILADELPHIA GENERAL HOSPITAL

By JOSEPH C. DOANE, M.D., MEDICAL DIRECTOR, GENERAL HOSPITAL, PHILADELPHIA

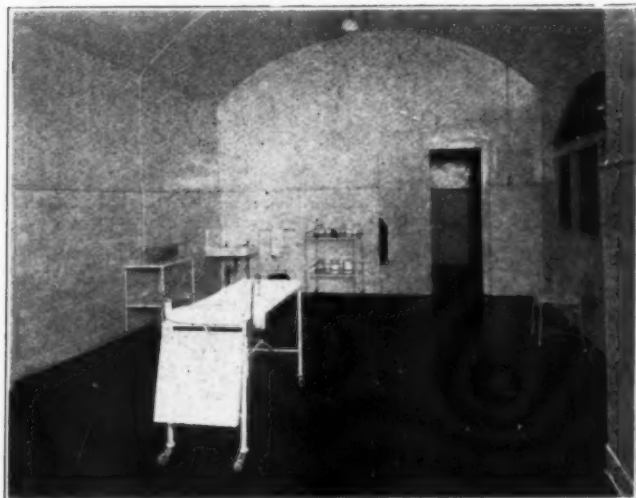
PHILADELPHIA was the first city in this country to purchase radium for the treatment of neoplastic disease in a municipal hospital. Save in a few instances where large clinics were available for the diagnosis and treatment of tumors, the expense of this treatment has heretofore made it available only to the wealthy. Not only does the purchase of an ample supply of radium provide for the treatment of patients at the Philadelphia General Hospital who could not otherwise receive adequate care, but it opens up wide possibilities of research, adding to the store of scientific information concerning this element and its place in the treatment of disease.

It is the policy of the department of public health to proceed very slowly in the development of the radiological clinic at the Philadelphia General Hospital. After months spent in constructing a suitable clinic suite, during which every detail was given the closest attention, the clinic was made ready for the beginning of actual work late in 1921. A staff of specialists was appointed and held its first conference on January 23, 1922. This conference meets each Monday, at noon, and is attended by all the mem-

are given and return cases examined. It is possible by this system for twenty or thirty cases to be seen daily. There have been assigned to the department eighty hospital beds which can be utilized for the care of patients suffering with neoplastic disease. Since certain patients may require applications, ranging in time from two to twelve or fifteen hours and will need observation



Reception room in Radiological Clinic.



Treatment room in Philadelphia Radiological Clinic.

bers of the staff with their assistants. The staff, as organized, consists of a dermatologist, surgeon, urologist, gynecologist, radiologist, laryngologist, oral surgeon, internist, pathologist, physicist and senior assistant medical officer.

Each visiting chief has a designated hour for conducting his clinic, at which time all treatments

during this time, two four-bed wards with diet facilities have been constructed in the clinic suite, where ambulant cases may be treated without entering the hospital proper.

Since radium and x-ray are used conjointly in the treatment of neoplastic disease, it became necessary to purchase new equipment for the last-named department and to completely rearrange and reorganize the apparatus formerly used. A high-voltage machine with a twenty-inch spark gap, the first of its kind in the city, has been ordered and will be ready for use shortly. It has been thought best to divide the work of the x-ray department between two visiting physicians, one to have charge of the therapeutic and the other of the diagnostic work only. The new electrothermic method of coagulation, which is an established mode of procedure for removing the foul and exuberant sloughs in advanced cases of malignancy, is to be used in connection with this department.

The nursing staff of the radiological department consists of a graduate nurse in charge of



Ward for ambulant cases requiring 24 to 48 hours for treatment.

the clinic, and one for each of the wards, with an appropriate number of pupil nurses, as required by the exigency of the service.

In order that there may be the proper coordination of the efforts of the radiological staff, a full-time resident radiologist was secured, who with his assistant closely follows the ward treatments, supervises dressing and is responsible for placing and removing all radium applications.

It has been thought best, when possible, for patients to be referred by their physicians for treatment either in the out-patient department or in the hospital wards. In this way the staff is aided by being able to secure a medical history of the development of the disease, as well as to arrange for the continued interest of the family physician, who referred the case, after the patient has been discharged from treatment. Patients who have not consulted a physician may apply at the radiological department of the Philadelphia General Hospital for treatment daily, except Sunday, from 9 to 10 a. m. at which time they will be examined by the resident medical officer and referred to the proper clinic for treatment.

The radiological staff desires the cooperation of all members of the medical profession in referring cases of neoplastic disease early to the clinic for treatment, since it feels that no measure can be efficacious if the disease is allowed to progress to a late stage. In order that the service of this clinic may be of the greatest value to the people of Philadelphia not only are marked and easily diagnosed cases of neoplastic disease referred to the clinic but also cases of uncertain diagnosis for

thorough study by the radiological staff. Nor are malignant conditions only referred to the clinic, since the medical profession recognizes that there are many benign conditions which yield readily to treatment by radium and x-ray. Angiomata, unsightly nevi, keloids, and benign uterine hemorrhages of myopathic origin, as well as certain types of bleeding myomata, frequently yield to treatment by these agents.

The physical laboratory of the radiological department of the Philadelphia General Hospital was formally opened on November 30, 1921.

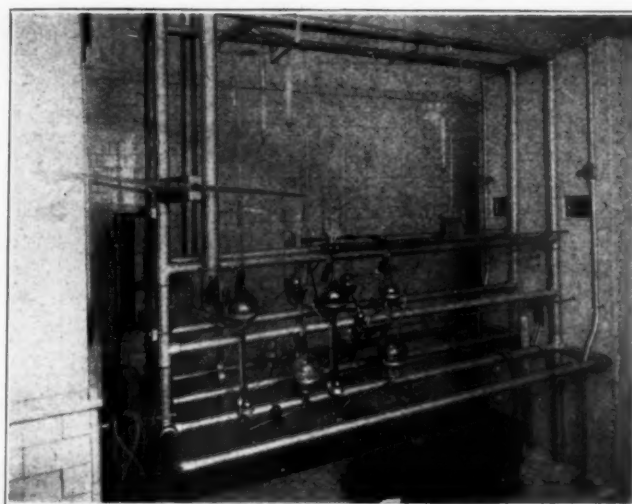
This division consists of an emanation room with its contained apparatus for the withdrawal of radium emanations from the two grams of radium; a technical toolshop where apparatus and instruments used in the preparation and application of radium emanations in the treatment of disease are constructed; a measuring room where the emanation is properly valued; and a preparation room, which is located in the out-patient department. The emanation apparatus, as well as other features of the equipment, has been patterned after that now in use in the Memorial Hospital, of New York. Certain improvements, however, have been embodied in the building of this apparatus, these changes being largely the result of the wide experience of the members of the Memorial Hospital staff in the preparation and application of radium. As a result, the equipment at the Philadelphia General Hospital is probably the most modern and complete possessed

by any radiology laboratory in the country.

The two grams of radium are kept in a lead-



Interior of safe containing two grams of radium from which emanations are collected daily.



Apparatus for collecting tubes of radium emanation, showing details of vacuum system.

lined safe in the emanation room, which is safeguarded by an elaborate burglar-alarm system and watchman.

About three hundred millicuries of emanation are collected every twenty-four hours and are placed in capillary tubes, which are later measured and forwarded to the out-patient department for application. Before the emanation is transferred from the laboratory to the out-patient department careful measurements are taken and the results are recorded in the measuring room on the third floor of the laboratories. The measurements are made by noting the time in seconds required to discharge an electroscope by a known standard of 25.24 milligrams of radium bromid, and comparing the time required to discharge the electroscope by the unknown tube of emanation to be measured. Taking into consideration the natural leak of the charge from the electroscope, the strength of the unknown tube can be computed.

The technician in the preparation room prepares applicators in accordance with the request of the physician attending the patient. A careful record is kept of each tube, and this record is corrected daily at the same hour in accordance with the known rate of decay. This system makes it possible to know at any time the total amount of emanation available for use.

A second measuring room is maintained in the radiological clinic to determine the strength of small bare tubes of 0.75 to 1.5 millicuries. These measurements require fifty to sixty operations, depending upon the number of bare tubes. After

the measurements are recorded about 100 mathematical operations are performed to get the strength of each tube.

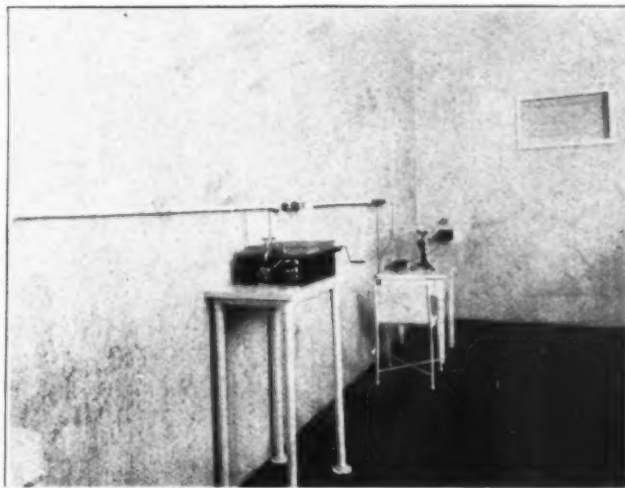
The routine just described, which makes possible the transfer of pure emanation from the radium solution in the laboratories in a form suitable for treatment, is carried on by a physicist, a technician and a glass-blower.

In order to make possible creditable research work, a well-

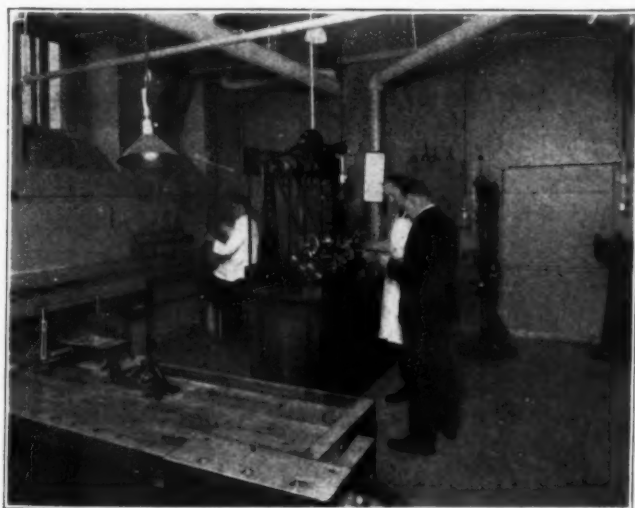
equipped shop has been established, where not only appropriate apparatus can be made for carrying on investigations with radium emanation but also where special apparatus for the application of radium emanation in the radiological clinic can be made.

There has been considerable interest along research lines shown by the various departments of the laboratories, and already work on six research problems has been started with the co-operation of the radiological department.

A radiological library is being collected to facilitate research work. It will be located in the radiological research room of the laboratories and will be available to those actively interested.



Ionization chamber and galvanometer used to measure the relative strength of used emanation tubes.



Shop equipped for making mechanical apparatus and for glass blowing.



Preparation room used for making various types of applicators.

LABORATORY FORMS FOR HOSPITALS

By HENRY J. GOECKEL, PHM.D., CRANFORD, N. J.

SINCE no set of laboratory report forms has been recommended to date by the American Hospital Association as a standard, a description of those prepared by the writer and used in Muhlenberg Hospital, Plainfield, N. J., may be of interest at this time.

The Muhlenberg Hospital forms were prepared not only to meet the needs of the laboratory; they also take into consideration the requirements of the nursing staff as well as those of the medical staff and of the historian of the institution. Their aim is to give a report which can be readily visualized, the essentials not being buried in a maze of "absent, normal or negative" notes. To note a multitude of unnecessary facts not only detracts from the value of the report but adds greatly to the time necessary to write reports and causes confusion in summing up and in posting the same.

Should Have Standard Examinations

Every well manned and properly supported laboratory should have standard types of examinations. Where the tentative or working diagnosis is not stated on the request form accompanying a specimen, a minimum only should be resorted to. Where such a diagnosis is stated the tests and methods should be modified and extended to confirm, extend or alter this diagnostic conclusion. By this means the time and resources of the laboratory are not wasted and in a measure this department will contribute to the maintenance of medical standards by making a working diagnosis an essential requisite for extensive laboratory aid. It will tend to compel a prompt physical examination and diagnostic conclusion and to prevent the all too prevalent habit of waiting for laboratory reports before forming a definite opinion.

Every hospital aspiring to be a first class institution should make it a rule that no laboratory reports will be given until a working diagnosis has been posted on the chart. By necessitating prompt physical examinations and history charting, this contributes to maintaining efficient physical diagnostic methods and tends to prevent the laboratory methods from overshadowing such basic methods. It will help to maintain laboratory procedures as a confirmatory aid and not as the major means to a diagnosis.

Symbols Should Be Used

Beside eliminating unnecessary topics on report forms, as far as it is possible to do so, the follow-

ing symbols are used in place of words in reporting. N. for normal, (—) for negative or absent, (±) for doubtful tests or results, (+) for slight traces or few, (++) for distinct traces or moderate number, (+++) for distinct tests or numerous, (++++) for a very strong test or for very numerous, (?) for no results where factors are missing, Ac. for acid, Alk. for alkaline, Sl. for slight, P. for pale, D. for dark, (%) for per cent, CC. for cubic centimeter, mg. for millegram, cmm. for cubic millimeter. Where these symbols are used their value is printed on all forms.

Our request or consultation forms are prepared in pads of sheets four by six inches (10x15 cm.). These are used to accompany all specimens excepting routing urines. They are more practicable than the case history size forms, are less bulky and easier to keep in the nurses' desks. They are more convenient when accompanying specimens as they can be attached to containers with the aid of an elastic band or a pin without folding. Specimens can be transported more con-

MUHLENBERG HOSPITAL PLAINFIELD, N. J. SPECIMEN FOR PATHOLOGICAL LABORATORY		
Lab. No.		
Name	Date	
Ward or Room	Service of Doctor	
Diagnosis .....	.....
Specimen of From		
Obtained	At	A. M. P. M.
If by special technic—state		
To be examined for		
To be used with sputum, feces, blood, milk, cultures, etc.		
For urine, use other forms.		
To be signed by nurse or physician making out this form and sent direct to the laboratory.		

Fig. 1.

veniently and placed more compactly on the receiving trays. The inconvenience of large forms causes breaking and spilling of specimens or loss of time and space. These forms are to convey requests and instructions to the laboratory and

should be retained there as part of its records.

This form (Fig. 1.) besides giving the name of the institution states that it accompanies a "Specimen for Pathological Laboratory" or "Request for Pathological Laboratory." A space is provided for the laboratory record number. No space is provided for noting the time when the request or the specimen was received at the laboratory. This being purely laboratory data its appearance on the printed form before reaching the laboratory is likely to cause confusion. If a receiving clerk or statistician is employed to receive specimens, he or she can record them numerically in the day book and then enter the record number and the time on the request form.

A space is provided for the patient's name, the ward or room, the date, the attending physician's name and a liberal space for the working diagnosis. The form calls for the designation of the kind of specimens, the organ or region, etc., from which it was taken, how it was obtained, requiring it to be stated when obtained by a special technic, and the time when it was obtained to enable the laboratory staff to know the age of the specimen when subjected to examination. Liberal space is allowed to state for what it is to be examined. The pathologist of course reserves the right to extend the examination beyond that requested if in his judgment the working diagnosis justifies a more extensive examination. The nurse or the physician writing the request is required to sign it. This is to enable the laboratory to establish contact with the person conversant with the case, should further information or instruction be required.

The reverse side of this form can be used to note the results of the examination. As all laboratory reports should be prepared in duplicate on case history size forms, recording results on the face of this form is unnecessary. If deemed of value rubber stamps can be used to stamp on the back the things to be reported on. This is only necessary where inexperienced help is relied upon to make the examinations.

Upon completion of the examination, since all essential data are now on this form, including the record number, the report can be prepared from this and the request form either filed numerically or returned to the clerk for assembling the data according to the statistical requirements of the laboratory and the hospital. At the end of a year these records can be destroyed.

Forms of Urine Examinations

Two kinds of urine report forms are employed. One which is kept in the wards is of the same size as the general request form and is designated as

MUHLENBERG HOSPITAL	
PLAINFIELD, N. J.	
HOUSE URINE REPORT	
Name .....	.....
Ward or Room.....	Date.....
Doctor .....	.....
Diagnosis .....	.....
EXAMINATION	
Color	Transparency.....
Reaction	Odor.....
Specific Gravity	Sediment
Albumin .....	.....
Sugar .....	.....
Bile	Urea.....
Indican	Acetone.....
MICROSCOPICAL	
Casts .....	.....
Epithelia .....	.....
Pus .....	.....
Blood Cells .....	.....
Crystals .....	.....
Amorphous .....	.....

Fig. 2.

the "House Urine Report" (Fig. 2). The same spacing is provided to give the patient's name, ward, date, physician's name and the diagnosis. The first spaces provide for the results of the physical examination, i. e., color, transparency, reaction, odor, specific gravity and sediment. Then come spaces to provide for chemical data, i. e., albumen and sugar, and in smaller type for bile, urea, indican and acetone, which are only examined for and reported on in casual routine urines when specially requested.

Under the heading of microscopic examination, space is provided for casts, epithelium, pus, blood, crystals and amorphous substances.

No record of these routine urine examinations is kept in the laboratory. The form accompanying the specimen, with the results of the examination noted thereon, is returned to the wards where the results are posted on the special laboratory form to be described later. When posted the slip is destroyed and not preserved with the history. This keeps down the bulk of the history forms and avoids confusion.

For complete clinical examinations on twenty-four hour specimens of urine, on cystoscopy and on renal function test specimens, a special form of case history size and style is employed (Fig. 3).

MUHLENBERG HOSPITAL PATHOLOGICAL LABORATORY PLAINFIELD, N. J.									
Path. No.	Date	Time voided	Ward						
Name <i>Wm. H.</i>	<i>9/14/21</i>	<i>Service of Dr. R. J. W.</i>							
Diagnosis (Tentative)									
URINE EXAMINATION									
Color	N	N	N	N	250 cc	100 cc	249 cc	58 cc	
Volume	1	1	1	1	1	1	1	1	
Appearance	1	1	1	1	1	1	1	1	
Sediment	++	++	++	++	++	++	++	++	
Reaction	0	0	0	0	0	0	0	0	
Specific Gravity	1.014	?	?	1.020	?	1.016	1.016		
Albumen	+	+	+	+	+	+	+		
Sugar	-	-	-	-	-	-	-		
Occult Blood	-	-	-	-	-	-	-		
Urea	1.4%	?	?	1.8%					
Bile	-	-	-	-	-	-	-		
Indican	N	N	N	N	N	N	N		
Acetone	-	-	-	-	-	-	-		
Diacetic Acid	-	-	-	-	-	-	-		
Creatinine	N	N	N	N	N	N	N		
Total solids						3.35 gm	2.425 gm		
Time					9 min.				
Plasma Solids						30%	13%	43%	
MICROSCOPIC EXAMINATION									
Casts Hyaline	-	-	-	-	-	-	-	-	-
Casts Granular	-	-	-	-	-	-	-	-	-
Epithelium	N	++	+	N					
Pus Cells	++	++	-	++					
Blood Cells	-	-	-	-					
Crystals	-	-	-	-					
Amorphous	-	-	-	-					
Mucus	++	-	-	++					
Bacteria	-	-	-	-					
Streptococci	+++	++							

NOTE: (-) = None; +, doubtful trace or test; ++, slight trace or few; +++, distinct trace or moderate number; +++++, distinct test or numerous; ++++++, very strong test or very numerous; N, normal.

Examined by *H. J. Soebel*

Fig. 3.

This is of a pale blue color and can be used for practically all kinds of urine examinations. The first line provides for the pathological laboratory record number, the date, the time when voided and the ward designation. The next line provides for the name of the patient and of the physician who has charge of the case. The third line provides for the diagnosis which accompanied the request.

The form is ruled to permit eight reports to appear in parallel columns. This allows the form to be employed not only for a general clinical report but also for cystoscopy reports, for the results of a fractional series such as the Mosenthal functional test, and for the results of the phenolsulphonephthalein test. These are reported on more extensively by this laboratory than is the case in most hospitals, as will be seen by the reports posted on the illustration to give an idea of its adaptability to the needs of the institution.

Where several clinical examinations have been reported on the same case, eight of them can be posted on the same sheet, thereby eliminating seven sheets from the filed history. At the same

time the results of all the examinations are shown by convenient contrast.

At the top of each column a space is provided for entering a descriptive designation to show if the specimen is a twenty-four hour one, or the date of voidance, or if it is a voided, a catheterized, a bladder or a right or a left ureter specimen. Then in consecutive order there are spaces for the color, volume, appearance, sediment, reaction, specific gravity, albumen, sugar, occult blood, urea, bile, indican, acetone, diacetic acid and

Path. No.	Date	Time	Ward
Name <i>Wm. H.</i>	<i>May 9, 1921</i>	<i>9 A.M.</i>	<i>Service of Dr. L. J. W.</i>
Diagnosis (Tentative)	<i>Pernicious Anemia</i>		
BLOOD EXAMINATION			
Coagulation Time	Leucocyte Index		
Hemoglobin <i>36.5%</i> Index <i>0.970</i>	White Cells per Cmm <i>1,400</i>		
Erythrocytes per Cmm <i>1,852,000</i>	Differential Count		
Polychrome cells <i>10,500</i>	Total Leucocytes <i>362%</i>		
(Reticulated) <i>3,500</i>	Polymorphonuclears		
Normoblasts <i>587</i>	Neutrophils <i>28.4%</i>		
Megaloblasts <i>1,760</i>	Eosinophils <i>4%</i>		
Shadow cells <i>5,060</i>	Basophils <i>—</i>		
Plasmodia <i>None</i>	Mononuclear Leucocytes <i>6.4%</i>		
Agglutination for <i>—</i>	Transitional Leucocytes <i>1.0%</i>		
	Irritation Leucocytes <i>—</i>		
	Total Lymphocytes <i>63.8%</i>		
	Small Lymphocytes <i>55.4%</i>		
	Large Lymphocytes <i>8.4%</i>		
Complement Fixation Tests			
For Syphilis <i>Negative</i>			
For Tuberculosis <i>—</i>			
mg. per 100 cc.		Hydrogen-ion Concentration or	
Creatinine <i>0.5 - 1.2</i>	Found	Alkali Reserve	
Urea <i>5.0 - 24.0</i>		Bicarbonate Content	
Uric Acid <i>0.5 - 3.0</i>		CO ₂ Tension of Alveolar Air	
Sugar <i>50.0 - 100.0</i>			
Chlorides <i>520.0 - 995.0</i>			
Culture		Camera sketch of red cells.	
		<i>0.8 x 1/2 in. 0.6 x 1/2 in. 160 mm.</i>	
		Examined by <i>H. J. Soebel</i>	

Fig. 4.

creatinin. Four blank spaces follow for occasional tests and then one for the phenolsulphonephthalein test.

Under the heading of microscopic examination space is provided for hyaline casts, for granular casts, for epithelium, pus, blood, crystals, amorphous material, mucus and for bacteria. When the present lot of forms is exhausted a space will be provided for cylindroids and one for cultures. The printer gave too much prominence to the note on the symbols used. A more liberal space was to have been left after the word "bacteria" to permit posting remarks where indicated.

The part reserved for microscopical examination should have been ruled in the same way as the rest of the form.

Forms for Blood Examinations

The report form for blood examinations is of case history size and of an orange yellow color (Fig. 4). Besides having the same heading as the urine report form, the sheet is blocked off into six parts. The upper left side has headings for the coagulation time, hemoglobin per cent and hemoglobin index and for the number of erythrocytes per cubic millimeter. Then a liberal space is allowed for a description of the red cells and for noting abnormal forms. A space is also provided for plasmodia and one for an agglutination test. On future editions four spaces will be allowed to permit posting the results of an entire typhoid colon series of agglutination tests.

Following this is a block reserved for complement fixation tests. A space is indicated for the results for syphilis, for gonorrhea and for tuberculosis. Space is allowed for three more headings.

The next block is reserved for noting creatinin, urea, uric acid and sugar in millegrams per hundred cubic centimeters. Space is allowed for entering four more of such examinations.

The right upper block takes up one-fourth of the form and is reserved for the white cell count. Space is provided for the leucocytic index, white cell count per cubic millimeter, and under the heading of differential count is a space for total leucocytes, the figures being carried far to the right beyond where the various types of leucocytes are noted, i. e., polymorphonuclear neutrophils, eosinophils and basophiles, mononuclear leucocytes and transitional leucocytes. Then there is a heading for total lymphocytes followed by subheadings for small and for large lymphocytes. Seven spaces are then allowed for occasional types of white cells.

Below this is a block for the hydrogen in concentration, the alkali reserve and bicarbonate content of the blood, and for the carbon dioxide tension of the alveolar air. Four spaces are allowed for other tests.

Across the sheet where blocked for the results of the blood chemistry determinations is a note, "State if special tests are on weighed or measured volumes of blood or serum." The lower fifth of the form is reserved for culture reports and remarks and for the signature of the examiner, the words "examined by" indicating the place for the signature.

The gastric examination form of a light cream yellow color provides for reporting the results of

Fig. 5.

the examination of a specimen taken from the fasting stomach and for fractions of the contents at quarter hour intervals for three and one-half hours after a meal. In all space is provided for fifteen fractions, the maximum likely to be obtained in a Rehfuß series.

As will be noted in the illustration, (Fig. 5) following the same headings as on preceding forms, about half of the form is taken up by a graph chart prepared by the writer. At the top is indicated "Fractions of Stomach Contents.—Time in Hours." On the next line "F. S." for fasting stomach appears, and $\frac{1}{4}$, $\frac{1}{2}$, etc., to $3\frac{1}{2}$ to indicate the time when the fraction was taken. At the zero and hour intervals a heavy line goes down the entire form to block off each hour. To the left of the chart is noted at ten cubic centimeter intervals, the lines for decinormal hydrochloric acid equivalents of the gastric contents, from zero to one hundred cubic centimeters. To the right of the chart is indicated the percentage equivalent by weight of hydrochloric acid, the tenth, two-tenths and three tenths being marked.

On the chart are printed graphs for the types of normal curves for free hydrochloric acid and

for combined acid. These were prepared from averages as ascertained by Hawkes*. The heavy solid line indicates the normal free acid curve (N. F. A.) and the dotted line indicates the normal combined acid curve (N. C. A.) For contrast the curves charted from the examination are most satisfactory when made with a laboratory blue pencil.

Space is provided to note free acid, combined acid, mucus, lactic acid, occult blood, bile and pep-

MUHLENBERG HOSPITAL PATHOLOGICAL LABORATORY PLAINFIELD, N. J.			
Path. No.	Date	Time	Ward
Name	Service of Dr.		
Diagnosis (Tentative)			
EXAMINATION OF			
From (organ or tissue involved)			
Obtained by			
General Characteristics of Specimen			
Color	Odor	Consistency, etc.	
Conclusions			
Examined by			

Fig. 6.

sin, and two blanks. Then follows an explanation of the symbols and a liberal space for the microscopic results and remarks followed by the words "examined by."

Loosely combined organic acids are not determined separately as this in the writer's opinion has very little value, not sufficient to waste the time and resources of the laboratory on. Total acid is not reported. Each factor, i. e., the free acid and the combined acid is noted separately. The sum of these being the total acid, it is left to anyone desiring this figure to do his own addition and graphing of it.

Miscellaneous Examination Forms

For other examinations a general form of a gray color is provided (Fig. 6). This provides for the same record data as all preceding forms and then in heavy type at the center are the words "Examination of." On the next line "From (organ or tissue involved)" and "Obtained by" to indicate the method by which it was secured. Five lines of space follow for this, and then "General Characteristics of Specimen" followed by the sub-headings "color," "odor" and "consistency" which are noted where appropriate. The rest of the form

*Hawkes' "Physiological Chemistry."

MUHLENBERG HOSPITAL LABORATORY CHART													
NAME <i>J. B.</i>		WARD <i>ack</i>		ADMISSION NO		DISCHARGE NO							
URINE EXAMINATION													
NOTE: Use the following symbols in charting (-), None; $\frac{1}{2}$, doubtful trace or test; $\frac{1}{4}$, slight trace or few; $\frac{1}{2}$, distinct trace or moderate number; $\frac{3}{4}$, distinct test or numerous; $\frac{5}{4}$, very strong test or very numerous; N, normal; Ac, acid; Alk, alkaline.													
DATE	SP GR	VOLUME	REACT	ALBUMEN	SUGARS	BILE	ACETONE			HYALINE	GRAN	PUS	BLOOD
1/10/20	1.010	?	Ac	-	-	-	-			-	-	-	-
22	1.012	?	Ac	-	-	-	-			-	-	-	-
30	1.010	?	Ac	-	-	-	-			-	-	-	-
2/4/20	1.012	?	Ac	-	-	-	-			-	-	-	-
2/14/20	1.024	9	Ac	+	-	-	-			-	-	++	-
18	1.030	?	Fl. Ac.	-	-	-	-			-	-	-	-
Blood Examinations													
DATE	HGBL	INDEX	RED CELLS	WHITE CELLS	NEUTRO	EOSIN	LEUCOC	LYMPH	PLASMA	Remarks			
1/10/20	?	?	?	17,600	79	2	0	18		New			
26	?	?	?	16,200	62	1	0	37		New			
2/10/20	30%	0.607	2,470,000	18,200	78	0	1	21		New			
21	?	?	?	12,400	80	1	0	19		New			
30	44%	0.7	3,200,000	32,500	81	0	3	16		New			
5/12/20	58%	0.69	4,200,000	10,000	59	2	0	39		New			
Miscellaneous Examinations													
DATE	EXAMINATION OF	FOR	RESULT OF EXAMINATION										
1/10/20	Feces	Blood, etc	Blood ++, Tubercle bacilli not found										
2/10/20	Blood	Wass. R. & S. C. F.	Wass. R. - Neg. Gonococcus R. - Neg.										
27	Placental Fluid	General	Cl. neg., Leuco ++, T.B. etc. not found										
27	"	Wass. R.	Wass. R. - Neg. S. C. F. - Neg.										
3/5/20	Pur. Salivary	Bacteria	Consid. streptococci - no T.B. found										
31	Pur. Salivary	Bacteria	Ward # streptococci - all showing in agar										
5/12/20	Pur. Sputum	Bacteria	Ward exam. - Neg. Culture - for staphylococcus										
NOTE: Where in doubt of results under Miscellaneous Heading, either consult physician before charting or refer to the original report.													

Fig. 7.

is blank excepting the lower one-quarter, a heavy line, dividing this from the rest for "Conclusions" and the space to indicate whom it was "examined by." This form is used for tissues, sputa, milk, etc.

The last form of this series is a "Laboratory Chart" (Fig. 7) which forms part of every bedside chart. It provides for the name, the ward and the admission and discharge numbers. The admission and discharge numbers are filled in only when one of the forms is used to provide a summary of the laboratory examinations for another institution or for a physician. Space is then provided to note the most important factors from fifteen urine examinations. Topics are provided as follows: date, specific gravity, volume, reaction, albumen, sugar, bile, acetone, two blanks, hyaline casts, granular casts, pus, blood, and one more blank.

Then a block provides for six blood counts, providing for the date, hemoglobin per cent (% Hgbl.), index, red cells, white cells, polynuclears, i. e., neutrophils (neutro) and eosinophils (eosin.), mononuclear leucocytes (monoleucos.), lympho-

cytes. Ruled blank columns, three small and one large, are also provided. Then there is a block for nine "Miscellaneous Examinations." The topics are the "date", "examination of" "for" and "results of examination." This block is followed by "Note: Where in doubt of results under Miscellaneous heading, either consult physician before charting or refer to the original report."

This form provides sufficient space to summarize the results of all laboratory examinations on practically all cases. It is figured for a two-week period. Should more examinations be made another one of these charts can be attached to the history. This chart aims to conveniently visualize the progress of the case. Being a part of the standard chart this form is white.

These forms are of different colors to show at a glance which case has had laboratory assistance beyond a routine urine examination and the type of examinations that were made. The colors should be such as contrast well the typed or written data. All lines being aids to the eye only should not be too heavy. A light green is used across the sheets for ordinary spacing and a light pink for blocking where lines and blocks are advisable.

HOSPITALS AS CHARITABLE INSTITUTIONS

The right of the hospital to seek public support is well put in a letter from the architect, F. H. Ellerbe of St. Paul, which is published in the annual report of St. Mary's Hospital at Duluth, Minn. Mr. Ellerbe planned the new wing of St. Mary's Hospital which is now under construction. His letter follows:

"There has always been a question in the mind of the public as to whether or not a hospital which demands or accepts pay for its services can properly be classed as a charitable institution, and thus be entitled to share in funds that are raised for charitable purposes.


"Inasmuch as no two hospitals operate under exactly similar conditions, it would obviously be impossible to class them all alike in this respect, but with the exception of a comparatively few strictly private institutions practically all hospitals are expected to, and actually do, furnish a great amount of service either entirely free or at much less than actual cost.

"It is now generally conceded that a hospital operated for charitable patients only is not altogether desirable. Many considerations lead to this conclusion, principal among which is the difficulty of securing proper medical attention and suitable facilities for diagnosis and treatment. The hospital which is caring for private cases must provide facilities and it attracts the best men to its staff. The eminent men have always been willing to devote a reasonable amount of time to charitable cases, and it is quite apparent that the limited amount of time which they can be expected to devote to such work can be employed more effectively if the charitable patients are accommodated in the same building with the pay patients, where the physician can attend them without loss of time and where they can have the advantages of the expensive facilities provided for the pay patients. Therefore, the fact that a hospital is receiving pay patients does not, and should

not, remove it from the class of charitable institutions.

"Moreover, there is a large class of people who require hospital service and who are willing and able to pay a limited amount, but not enough to cover its actual cost, to say nothing of a profit, and such service is as much of a charity in kind, if not in degree, as that for which no charge is made. There can be no doubt but that the public appreciates this fact. The fact which it does not appreciate and which leads to the misconception in regard to this kind of service and raises the question above referred to in the mind of the public is the cost of hospital services. Most hospital rates were fixed years ago when prices were comparatively low and where there has been any advance in recent years, it has been moderate in comparison with the increased operating cost, which during the past few years has amounted to at least 70 per cent. This estimate is conservative, for most of the larger items entering into the calculation, such as labor, fuel, chemicals, food, linen, glassware, etc., have increased from 100 to several hundred per cent. Even the old rates for ward beds were considerably below cost, which fact can be readily appreciated if a comparison is made between them and the hotel rates which prevailed at that time. The hospital rate was almost invariably lower than those of the hotel operating upon the American plan, while the hospital service was very much more expensive than the hotel service. In a hotel the guest does not receive any personal attention that he does not pay extra for, and his meals are served in the dining room. In the hospital the patient receives a large amount of personal attention and a majority of his meals are served in his room. In the American hotel, no special meals are served; in the hospital a large number of special meals are prepared every day. In the hotel of moderate size the personnel (staff and employees) will average one or less to each five guests; in the hospital of moderate size the personnel will average one or more to each patient. The hotel has many other sources of revenue; the hospital has none except what is received directly from the patient. The operating cost of a hotel has advanced in about the same proportion as that of a hospital, but their rates have been advanced in approximately the same proportion and it is doubtful if they will ever get back to a pre-war basis. A prominent hotel operator recently admitted in an article in the Literary Digest that many hotels, prior to the prohibition act, would have been operating at a loss had it not been for their revenue from the sale of liquor.

"If the hospital was expected to have the same earning capacity, it would be necessary for it to charge rates at least twenty-five per cent higher than those of a corresponding hotel, and the comparison would usually have to be made with a first class hotel occupying a fireproof and expensively furnished building. Even to pay expenses the hospital would have to charge as much as the average first class hotel, but, as a matter of fact, hospitals do not and cannot charge such rates except to private patients of the well-to-do class and consequently an operating deficit is created. This deficit can sometimes be partly absorbed by the profit made from the comparatively few well-to-do private patients who can afford to pay a rate which will result in a profit. This profit is, however, seldom sufficient to make up the entire deficit and is never sufficient both to meet the deficit and provide for necessary replacements and extensions. Therefore, the hospital which is accepting any considerable number of free cases and patients who do not pay full rates is unquestionably entitled to a full share of public support and the friends of such hospitals can, with the utmost propriety, demand their recognition as charitable institutions."



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SEPTEMBER 25-28

IF PRESENT plans mature, the exposition of equipment and supplies will more nearly take its rightful place at the forthcoming meeting of the American Hospital Association than in any previous year. A renewed effort will be made this year to break away completely from the deadly practice of having delegates listen hour after hour for four successive days to formal paper after formal paper. Last year's effort in this direction was only partially successful.

The exposition, to be sure, has always been regarded as an integral part of the convention. The practice hitherto, however, has been to keep it more or less in a watertight compartment. Its existence was routinely announced from the platform and delegates were urged to study it. But such was the crowded condition of the program that delegates found it exceedingly difficult to follow the suggestion. It meant either the neglect of some important meeting or a hurried visit in the late afternoon or after the evening sessions.

This year there is to be a fairly radical change for the better. Not only does the conference program set aside definite periods of time for the study of the exposition, but early sessions of the conference will be devoted largely to the reports

of special exposition committees. To these committees have been assigned the important duties of examining the exposition critically and reporting what may be learned by delegates and the best way for them to learn it. Furthermore, it will be the duty of these committees to acquaint delegates with the best hospital practices pertaining to the sections of the exposition they are asked to cover. This is an admirable plan and should enable delegates to get the most out of the exposition with the least expenditure of time and effort.

During the past year the association has had five or six special committees actively at work seeking solutions to some of the hospital's most trying problems. These committees will submit their reports at the conference. They will deal with gauze renovations and standardized dressings; hospital floors; forms and records, with particular reference to the annual report; the relation between hospitals and the states and cities in which they are located; and training for hospital social work.

The conference will be enriched by concurrent meetings of allied national bodies dealing with certain phases of hospital work. These will include the American Association of Hospital Social Workers, The American Occupational Therapy Association and the Protestant Hospital Association.

One of the new features which will undoubtedly prove stimulating will be the organized visits of delegates to some of the hospitals in New York and Philadelphia. The special features of these hospitals will be emphasized and illuminating demonstrations given.

All in all the Atlantic City convention promises to be one of the most helpful of recent years, and trustees should see that the superintendents of their institutions attend. With the inauguration last year of a trustee section, trustees themselves will find attendance upon the convention eminently worth their while.

THE DISPENSARY PROGRESSES

IN ITS issue of August 5 the *Journal of the American Medical Association* presents the first of a series of articles relative to the statistical data on dispensaries collected by the council of medical education and hospitals of the American Medical Association. This article is devoted to a presentation of the data pertaining only to general dispensaries; later articles will deal with special dispensaries and clinics, such as tuberculosis, mental hygiene, venereal disease, baby and child hygiene, and eye, ear, nose and throat dispensaries, together with industrial dis-

dispensaries and clinics devoted to group practice.

It is interesting to note that whereas in 1916 Davis and Warner in their book on dispensaries place the number of these institutions at 900, this survey gives definite information in regard to 3,243 dispensaries, and its authors believe there is authoritative evidence enough to hazard the statement that there are a total of at least 4,000 dispensaries in the United States.

Consideration of the figures gathered gives one some conception of the stupendous amount of work done in these institutions. The 946 general dispensaries from which reports were received handled 3,872,345 patients during the last fiscal year. They made 11,789,887 visits. Including a reasonable estimate for the dispensaries that did not report, the authors believe these figures would be increased to 4,250,000 patients and 13,500,000 visits. These figures are quite exclusive of the special dispensaries and clinics which cared for 3,750,000 patients during the year, who in that time made 16,000,000 visits, bringing the grand total up to 8,000,000 patients who made 29,500,000 visits. The article calls attention, however, to the fact that the number of separate individuals who use the dispensaries and clinics is somewhat less than 8,000,000 since allowances must be made for those who visited two or more institutions during the year.

The tables included in the article give the distribution of general dispensaries by states, the number and work of the general dispensaries in the fifty largest cities; the number of physicians serving in general dispensaries, whether on full or part time; the types of teaching carried on in general dispensaries; the out-patient service in hospitals approved for internships; the financial support of general dispensaries; and the number of social workers employed in general dispensaries, whether paid or volunteer. These tables warrant careful study. Some of the main facts brought out by the survey are:

1. There is a steady increase in the number of patients seeking treatment in general dispensaries.

2. There has been an unprecedented increase since the war in the number of special clinics and dispensaries, such as those for tuberculosis, venereal disease, mental hygiene and child hygiene.

3. There is great need for individualized study and treatment of dispensary patients, to counteract what seems to be a prevailing tendency to routinization.

4. There is need of a closer bond between the out-patient service and the other service of hospitals, and this will best be met by having the hospital and the out-patient staffs identical and by keeping unified records.

5. In the matter of finances there is an increasing tendency to charge nominal fees, thereby placing part of the cost of an institution on the patient.

6. A general increase is noted in the use of social service workers to see that patients continue their treatment, and to investigate their social and financial status so as to prevent pauperizing.

7. The difficulty of securing satisfactory data is increased by the inadequacy of clinical and office record systems in a large number of institutions.

8. There is a great and increasing amount of educational work, especially the teachings of interns, medical students, graduates and pupil nurses.

Commenting on the almost unbelievable increase in the number of dispensaries established during the last decade, the *Journal of the American Medical Association* observes that "the increase in population in the country has had some influence on the development of out-patient dispensaries, but the chief stimulus, especially in recent years, has been the increasing popularity of the dispensary as a place to secure satisfactory medical service. It has been during recent years also that dispensaries have established well-organized medical staffs and have required their prompt and regular attendance. In addition to this, there has been an increasing tendency toward the establishment of graduated scales of fees by which those who were unwilling to accept charity at the free dispensaries are more willing to patronize the institutions. Another influence leading to the increase in numbers is the recognition by hospitals of the importance of out-patient departments as a means of better serving the people in their communities. It is found that many hospital patients during convalescence can secure the necessary follow-up treatment as ambulatory patients of the out-patient departments."

But whatever the causes for this remarkable increase in the number of dispensaries and the variety of their work may be, it is evident that the dispensary, the potentialities of which have hitherto been foolishly ignored, is fast taking the place in our medical economy that it deservedly should.

SAFETY CORPS

IN HIS article on "Hospital Signal Systems" on page 247 of the current issue Mr. E. Newton-Wells makes a recommendation that should be acted upon more generally by hospitals. He recommends that in every hospital there be or-

ganized a safety corps whose duty it will be, in the event of fire, to meet upon signal at a given point and if possible extinguish the blaze or assist in moving patients to points of safety. Our attention has been called to a number of instances of incipient fires which have been extinguished by safety corps so quickly and quietly that even the patients in nearby rooms knew nothing of the danger. They have often thwarted what might easily have developed into a holocaust.

The organization of safety corps is so simple a procedure and the work they may do at a critical moment so vital that it is difficult to conceive of a hospital without one. However fire-resisting or fireproof a hospital may be, it is not, as Mr. Wells pertinently points out, free from fire risks due to panic, smoke, etc. Safety corps can do much to minimize the risks if not avert them altogether.

PRICE NOT THE ONLY CRITERION

THE unprejudiced mind, we feel confident, will gladly concede that the hospital should use only high grades of supplies, especially medical supplies. And yet word comes to us every now and again of hospitals that buy their supplies solely on the basis of price with a total disregard of the factor of quality. Take alcohol as an example. Comparatively speaking the consumption of alcohol in the hospital is not very great and the total expense for this commodity would be relatively small even if the best quality were purchased. Nevertheless, not a few hospitals in making up their medicinal compounds and even in the sterilizing of their surgical instruments are using an inferior grade of alcohol which in the long run is bound to be reflected in the quality of the institution's service.

Not even in the selection of preparations used for rubbing and bathing its patients can the hospitals be indifferent. The highest grades of preparations used for this purpose are the result of intensive study by technically trained men, so that the finished product is compounded of ingredients which have been chosen because of some specifically beneficial action.

Still many hospitals, taking price as their only criterion, do not hesitate to purchase preparations to the production of which only a modicum of study and experiment has been given.

Hospital superintendents should awake to the dangers of this tendency to disregard quality in the interests of price; not the least of these is the danger that manufacturers who would be ashamed to furnish hospitals with other than first grade medical supplies will discontinue their activities in this field.

FIRE LAWS FOR HOSPITALS

DURING its recent annual meeting at Atlantic City the National Fire Protection Association adopted a series of twelve resolutions advocating certain measures in its warfare against the needless sacrifice of human life and property by fire. Among these resolutions were two advocating the adoption by municipalities of the standard building code of the National Board of Fire Underwriters to the end that fire-resistive building construction may be encouraged, the use of inflammable roof coverings prohibited, adequate exit facilities from buildings assured and interiors so designed and fire-stopped as to prevent or materially retard the development and spread of fire therein, and the adoption by all states and provinces of minimum building requirements for the protection of public and private hospitals, schools, asylums and similar institutions.

Nowhere is protection from fire more imperative than in hospitals and kindred buildings where thousands of more or less helpless, bed-ridden patients are housed. These resolutions point the way to a more adequate protection, particularly of human life, and all interested in efficient hospital administration should use their influence persistently in seeing that these resolutions are acted upon by the responsible municipal, state and provincial authorities. Delay in a matter of such vital importance is a breach of public trust that is little short of criminal.

SYSTEM IN THE SORTING ROOM

THE sorting of the hospital's laundry after it has been washed looks like a simple process.

Yet have you ever spent a half hour in the sorting room of the laundry of a hospital in which the marking and folding of garments are left to personal whim or chance, instead of being controlled by a definite system? We have. And as we have watched the sorters fumble the garments in their efforts to find the laundry marks, we have been amazed at the amount of time and effort they wasted. Unguided by any system, the sorters, instead of looking in one place, often looked in three or four before the marks were finally found. Here surely is a fruitful field for the application of the adage, "A place for everything and everything in its place." In a series of three articles, beginning in this issue, Mr. Walter T. Williams deals in some detail with this subject. Some hospitals will doubtless wish to adopt the system of marking and folding he presents; but, whether his system is adopted or not, every hospital should establish some definite scheme for sorting its laundry expeditiously.

ESTABLISHING A NEW RECORD FOR HOSPITAL ENTERPRISE IN NEW ENGLAND

By GEORGE W. GARDINER, CHAIRMAN, CAMPAIGN EXECUTIVE COMMITTEE, HOMEOPATHIC HOSPITAL, PROVIDENCE, R. I.

DURING the week, May 7-15, Providence conducted a campaign to build, equip and endow a new home for the Homeopathic Hospital of Rhode Island in that city. The objective was \$1,000,000. The subscriptions by the close of the campaign, Monday evening, May 15, amounted to \$1,222,608, more than twenty-two per cent in excess of the goal.

This campaign was remarkable in many respects. In the first place, the fund subscribed is the largest on record for a single hospital enterprise undertaken and completed at one time anywhere in New England. It was much the largest civic project ever attempted in the city of Providence and by far the most successful.

There were eighty teams of workers, comprising more than 800 men and women, and they were given access to a list of more than 32,000 carefully selected prospects. The workers went over the lists persistently, selecting the subscribers they preferred to see, and in this way they rolled up a total of about 6,500 subscriptions. The average subscription was therefore \$188. Taking the population of Providence at 240,000, the fund subscribed is equivalent to over \$5 per capita.

Thirty-Bed Hospital Expands to 250 Beds

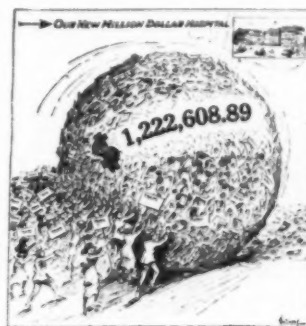
One of the outstanding features of the campaign was the fact that the present Homeopathic Hospital, which is to be replaced by the new structure, is a small hospital with a capacity of thirty beds and having a value of about \$30,000, whereas the new hospital that is now to be built will have a capacity of 250 beds and will be located upon a particularly well-chosen hospital site of eight acres for which the trustees paid \$25,000 five years ago. In other words, the campaign actually called for, not so much an enlargement of or an addition to the existing hospital, as the creation at a single stroke of a complete new hospital of almost nine times the capacity of the old one.

Those who took part in the campaign ascribed its conspicuous success to the thoroughness of the preparation, the forceful appeal made through publicity of a carefully conservative and soberly reasoned character, and a complete disciplined and enthusiastic organization of the working force.

The case for the new Homeopathic Hospital of Rhode Island was clear cut. In the publicity, facts, and yet more facts, were insistently presented. These showed how seriously the city was under-equipped in hospital facilities. A comparative table was used in the advertising and in the campaign literature which showed that among eight cities with which Providence might reasonably be compared, Providence stood last.

A persuasive appeal was based upon the fact that the Homeopathic Hospital of Rhode Island is an "open" hospital, where physicians of the old school as well as physicians of the new school may hospitalize their patients. It is the only hospital in the state which affords this privilege to physicians of the homeopathic school.

The policy of the hospital with respect to free service was effective in the campaign. The hospital was established in 1904, particularly for the benefit of the poor, and it has always given a large measure of free service. During the campaign it was announced that in the new hospital 122 beds will be free beds. The reputation of the hospital for medical and surgical treatment has been unquestioned.



Cartoons in Providence dailies helped the drive.

There were difficulties in the way. Coincidentally with the campaign of the Homeopathic Hospital other hospitals in the city were in need of funds and were planning campaigns. Business conditions were untoward, particularly because of the stagnation in the cotton mills through the Blackstone and Pawtuxet Valleys during a strike which had continued for seventeen weeks when the campaign closed.

Then, too, the city had never tackled so large a job in a civic way. Hundreds of those who were members of the campaign working force had never shared in a similar enterprise, and thousands of those who contributed had never participated in a hospital fund before.

Just before the campaign closed and while the final figures therefore were in doubt, Col. Webster Knight, president of the hospital, made the following public statement, which expresses a view that later became the general public verdict concerning the campaign:

"This is a wonderful thing that the workers for the new hospital have done. In four days' time, through an organization brought together for civic service, they have already rolled up a total of pledges greater than ever before gathered for a single civic enterprise here.

"They have tested and accepted the facts. They have recognized the need. They have volunteered their service, and they have gone out with disciplined enthusiasm in order to give their city larger hospital facilities.

"And they are getting what they went after. To have received from thousands of subscribers pledges of more than half a million dollars is in itself a splendid piece of work. But the increases in the amounts reported from day to day are perhaps even more remarkable. On the first day—which was, indeed, but half a working day—they brought in \$16,500. On the fourth day they brought in \$107,000.

"Such figures, however regarded, are amazing. They are a magnificent proof of the public spirit and the civil loyalty of the people of Providence, and they are an evidence of far more than mere money values. They mark the rise of a high tide of social endeavor for the common good which promises well for the future.

"This organization is largely composed of men and women who never before have teamed together for such a project as this. As a constructive body, working in concert, they are a new force in the democracy of our city. Their achievement is opening new doors of opportunity, new prospects of civic advance.

"Deeply as I rejoice because the good work of this organization in assuring the new hospital, I am scarcely less gratified at the thought that, through the activity of this fresh vital force, all Providence is awake to a new sense of self-reliance and power. What our citizens have done and will do for the new hospital is a pledge of what they can do in any other field when their minds are in full accord and their hearts are in unison.



Local papers gave much valuable publicity.

"If the movement for the new hospital had created only this inspiring example of cooperation for civic betterment, it would be worth all the effort that has gone into it. We of Providence have found within ourselves unlimited resources of service and achievement.

"In gaining the new hospital, our people will win for themselves a richer municipal life and a greater sense of power for all good uses. I look forward to Monday night with confidence and pride. All of us are enriched and uplifted because of the work we are doing together for our city, for ourselves and for those in need."

During the campaign much emphasis was laid upon the accessibility of the hospital site. The tract, which faces on Chalkstone Avenue, opposite Davis Park, is a converging center for three of the chief manufacturing districts of the city. It may be reached quickly by a direct route from the Union Station. Accident cases in the

mills, as well as emergency cases coming to Providence from out of town by railway, may be taken to the hospital at an average saving of seven minutes as compared with the other Providence hospitals.

An event that attracted widespread attention was the ceremony of breaking ground for the new hospital, held on National Hospital Day, May 12, in the midst of the campaign week. The Governor of Rhode Island and the Mayor of Providence were among the speakers, and Col. Knight dug the first shovelful of earth. Hospital nurses, boy scouts and girl scouts, the campaign executive committee and hundreds of spectators attended the exercises.

THE STATUS OF THE NURSING ATTENDANT*

By A. K. HAYWOOD, M.D., SUPERINTENDENT, THE MONTREAL GENERAL HOSPITAL, MONTREAL, QUEBEC.

THE misgivings that naturally come over one when dealing with an experiment were experienced by me when I accepted the invitation to speak to you this evening. The attendant's course which you have just completed and from which you are now being graduated, while not an experiment in the true sense of the word, is an experiment in this city and province.

The trained attendant first made her appearance in Boston in 1912 through the Household Nursing Association, but it was not until 1918 that a definite course of training was established and since that time several schools for trained attendants have been founded in Canada and the United States.

Innovations Bring Criticism

You are no doubt aware that the course which you have just completed is open to criticism, but it is mainly the criticism that one finds directed against any new project or innovation that tends to deviate from tradition or long established custom.

It is quite unlikely that these schools for attendants would have been established had there not been a demand for the class of service that you have been trained to render. This demand is urgent at the present time, and I have no doubt that you will find plenty of opportunities to practice your calling in this city, and it is in view of this probability that I would sound a note of warning.

A knowledge of the needs of this community convinces one that there are scores of families who, when illness overtakes them, will find in your services a blessing. I do not wish to intimate that you will be sufficiently versed in the art of nursing to take the place of the graduate nurse. Her position and knowledge are only made possible after three years of the hardest kind of work, study and sacrifice, and it is only natural that she will view graduation exercises as you have them this evening with apprehension; but I feel sure that the graduate nurse will realize in time that it is possible for her work to be supplemented by a body of women such as you represent. One cannot help but feel that in many cases of chronic illness, in convalescence, and in caring for children, the employment of a graduate nurse would tend to produce such financial embarrassment in that family that would make her employment impossible, nor is it right that on this account some form of service should not be available for this class of patient.

You are not nurses and my kindest advice to you is to recognize and remember that fact at all times. The nurs-

ing profession is an old one and has progressed and perfected itself by many trials and tribulations. Nurses have every just and sufficient reason to be proud and jealous of their prerogatives, and while it is my sincere wish that you should meet with every success in your limited field I hasten to warn you to avoid the paths of criticism.

Your course is still in its infancy. I understand that you are the second class to graduate, and to you is entrusted a great deal of the future success of this venture. You can rest assured that you will be watched with a great deal of interest, and there is no doubt that your mistakes and shortcomings will be made capital of to the detriment of this cause.

Need Practical Hospital Training

This course which you have just taken will undergo many changes. I hope I will not be misjudged if I venture a few suggestions as to those changes that at the present time might be profitably adopted. I cannot help but feel that your usefulness would be materially increased had it been possible for you to have supplemented your theoretical work with practical work in institutions that lend themselves to your particular class of work. By that I mean institutions for incurables, convalescents, certain classes of children's hospitals, or even small general hospitals without training schools in which there is difficulty in securing probationers. The question is bound to be asked why not general hospitals with training schools? The answer is that experience has proved in those hospitals that have combined the attendants' course with the nurses' course that it has not been successful. The attendant has had relegated to her the most menial duties of the wards without the interesting nursing care to make this drudgery bearable. There is inevitable jealousy and friction between the two classes of pupils.

Your future as attendants and your proper employment are largely in the hands of physicians, and I sincerely trust that the physicians that employ you will insist on continued supervision of your work, and by that supervision you will avoid the pitfalls that await you which if not avoided will bring your entire organization into disrepute.

To those who have been instrumental in enabling you to take this course, great credit is due. The Y. W. C. A. in fostering this work has done the community a real service. Whether you young ladies have undertaken this work as a means of livelihood or better to fit themselves for your home duties in case of illness matters not when

*An address to graduates of the second Attendants' Course given by the Y. W. C. A. in Montreal.

one realizes the lack of knowledge of the first principles of home nursing so prevalent in the young woman of today. One cannot but feel sorry at the young wife's apparent confusion when asked by her physician if she has taken a temperature, or at her lack of knowledge of the first principles of hygiene.

Urges Legislation Against Unscrupulous

I am sure that those who are fostering this cause have no intention, in giving recognition to the trained attendant, to provide a poorly trained nurse for the poor or middle class, and my last word of warning is to prepare now for legislation that will make it just as impossible for an unscrupulous attendant to practice as a nurse, as it is now impossible for a nurse to practice as a physician.

The community needs your services badly, and I hope that your course will be broadened and developed with a sincere view to a large community service. Our hospitals are now overcrowded, and we are told that only ten per cent of the sick of the community are in the hospital so you can see what a broad field is open to you.

In closing I would like to quote from an article that I came across in a recent number of the *British Journal of Nursing*—"We fear that the short term training of nurse attendants in Canada and the United States, who are "registered," is going to undercut standards and fees for genuine professional nurses. When the arrangement was agreed we felt sure that the profession was trifling with its economic stability. We note from our press cuttings from abroad that these 'attendants' have assumed the complete white uniform of the professional nurse. The Y. W. C. A. is responsible for turning out those graduates in Montreal, but we are told their training is not considered complete until they have been in attendance upon a certain number of patients. Let us hope such patients are not charged for trained services."

I read this quotation without passing any further comment. It senses certain fears of the nursing profession, but I am convinced that your organization is aware of these fears and will avoid them, and by so doing will command the respect and assistance not only of the nursing profession itself but of all others who have the interest of the community at heart.

PROFESSIONAL RECORDS FOR THE HOSPITAL*

PRECEDING papers in this series, supplementing and interpreting the report of the Committee on Hospital Forms and Records, discussed Divisions A, B and C of the report pertaining to the records used in accounting, purchase and issuance, administrative functions and to the necessity of providing a routine and ready method for the study and analysis of the institution's activities.

The remaining divisions of the report, D, E, F and G, pertain to the records of professional services, including clinical records, records of the school for nurses, social service and out-patient or dispensary service. The records used in these divisions will probably require less interpretation because they are more or less self-explanatory.

Patients' History

The reasons for keeping clinical records may be briefly summarized as follows:

1. To show at any later date an accurate record of the professional measures instituted in any given case.
2. To provide a basis for the analysis of the work of attending physicians and surgeons.
3. To provide a basis for research and study in medical practice.
4. To provide a means of instructing medical students in the proper method of making a diagnosis.
5. To provide the attending staff with a written record of the patient's progress.
6. To enable the hospital to fulfill its obligation to the patient in providing such record upon request.
7. To provide a basis for legal evidence if needed.
8. To stimulate adequate and competent service on the part of the attending physician and surgeons.

Numerous other reasons may be cited. The preparation and maintenance of a careful clinical history will serve as a definite stimulus to more accurate diagnosis and service by the attending physician.

*This article, prepared by A. C. Bachmeyer, M.D., F. E. Chapman and John Brennan, M.D., is the fourth and last of a series interpreting the report of the committee on forms and records which was made at the twenty-third annual meeting of the American Hospital Association in September, 1921.

Many of the forms submitted to the committee seemed to indicate that the making of the clinical record in some institutions is an intricate, cumbersome and time-consuming process, because of the many elaborate and specialized forms in use.

It is our belief that while the records should be adequate and complete, they should remain simple in form and permit the exercise of initiative and of freedom of expression on the part of physician and nurse.

Under Division D, subdivisions D-1-A to D-1-L, we believe are listed those forms essential in any clinical record. The forms submitted were of simple outline. All printed instructions to physicians and nurses were avoided, in the interest of economy.

There are many who prefer a definite printed outline to be completed by checks and affirmative or negative answers. Such records may well serve in individual instances, but as the outline used differs very materially the committee could not endeavor to select or recommend any particular form. It was therefore recommended that for the sake of uniformity in hospital practice, the plain and simple form be used. Emphasis however must be placed upon the necessity of adopting in each institution a definite procedure and system of history-taking; the attending staff should then be held responsible for the continued use of that system.

Because of the great number and variety of special forms in use and the cost of such forms, a warning was voiced in the report that special forms should only be adopted after careful consideration.

Attention is called to the fact that we are accumulating a vast volume of clinical records in the hospitals of this country and in Canada. This recorded experience of present-day methods in the practice of medicine is serving in a very meager and almost wholly local manner in improving methods of diagnosis and treatment. Some national mechanism is needed, whereby the information being collected may be analyzed and published for the benefit of the entire medical profession.

Under this heading, Division E of the report, seven forms were included. All are self explanatory and follow

for the most part recommendations previously made in other conventions.

The records necessary, in this instance, pertain to:

Information for the prospective student concerning the individual school. This is usually presented in the form of an announcement or catalogue. No recommendation concerning such announcement was made.

Information concerning the applicant. Such information can be secured in a definite way, by means of an application blank, previous school record, reference forms and physician's examination forms. Samples of these accompanied the report.

Information concerning the student while in the school. This information collected from instructors' and supervisors' reports can easily be noted upon definite record forms, samples of which were submitted.

All information should then be filed in an envelope so that at any time complete records of any nurse student can be obtained by referring to her individual file. If all correspondence concerning the student is likewise filed in the same envelope, it will prove a quick and ready reference in all instances.

Social Service

The opinion of the committee on social service records was voiced in the following paragraph of the report:

"A social history, name and family index card, with the addition of a follow-up tickler, would in all probability suffice as record forms for this department. The tendency to develop a heavy overhead of clerical work should be discouraged, and the workers left free to accomplish their purpose in the field. It is recommended that the above named forms, with a system of filing duplicates of social history under a 'social diagnosis classification' and the use of such files for statistical purposes at the close of any given period, be adopted."

Four forms were included under this heading and it is believed that they will suffice to give adequate records. We desire to call attention to the desirability of filing the social history with the medical history of the patient, in order that all information pertaining to the patient may be in one place and readily available for reference. Such practice will also bring the social facts of the case to the attention of the physician and serve to stimulate his interest in that phase of his patient's difficulty. Thus the physician's cooperation with the social service department will be promoted.

Out-Patient Department

The same fundamental principles that apply to the administration of a hospital proper are applicable to the dispensary or out-patient service.

The distribution of operating income and expense can be made in a similar manner to that of the hospital. Per capita cost should be determined upon a "per visit basis." Dispensary income and expense should be kept separate and not included in the same totals as that of the hospital proper, though they may readily be carried in the same books.

The specific data required in the dispensary comprise information concerning the admission and assignment of the patient, clinical record, social service record, discharge and follow-up record and instructions to the patient concerning return or re-visit.

A few of these special forms were submitted with the report. It was recommended that the same principles be followed here as in the hospital proper.

It is essential for efficiency of operation and control that the clinical records of the out-patient department and of

the hospital be intimately related. The ideal system would be one in which the records were identical and followed the patient from the dispensary to the hospital or vice versa. Frequent handling of records in the out-patient department requires usually a tougher grade of paper to withstand the wear and tear than is necessary in hospital records. A central filing room for both sets of records is a definite advantage. If the same record sheets cannot be used in both instances a system of abstracting the records of one department for use in the other should be established.

In conclusion, the committee desires to express its appreciation of the manner in which the work thus far done has been received. It recognizes that the recommendations and sample forms submitted will not without modifications apply in all instances. It is not intended that each hospital shall use every form mentioned in the report; a number of them will be found superfluous in many instances, and in many institutions additional records will be necessary.

We believe however that if the principles enumerated in the report are accepted and followed and if in general this scheme of record keeping is adopted, it will, through uniformity of practice, be productive of great good in the hospitals of the country.

By means of the use of some such system as this, plus the filing of annual reports with some central agency, such as the Hospital Library and Service Bureau where statistics might be compiled and published, there is an opportunity to prepare statistics that will be of great value and of assistance to each hospital administrator.

PAYMENT OF HOSPITAL ACCOUNTS

The time to make arrangements regarding the settlement of private accounts is when the patient is admitted, according to O. J. Decker, superintendent of the Toronto (Ont.) General Hospital. The rate of the room, operating room fees, special nurses' board, etc., should be clearly explained. If the patient is unable to pay at the time he is admitted, or not able to pay at all, there is nothing humiliating in saying so. There is no resentment from a frank business talk with a patient when he comes into the hospital. If the patient is too ill when admitted to the hospital to be questioned, then these questions must be discussed with the friend or relative accompanying him. Nine times out of ten in private cases someone will accompany the patient. One week's maintenance should be deposited in advance by every private patient admitted to the hospital. During the patient's stay the accounts should be rendered and sent to the patient on the day that the deposit, which was originally made, becomes exhausted. If a further payment is not made within a week, the patient's friends or relatives should be notified that in accordance with the rules of the hospital the patient will be transferred to a free bed unless settlement of the account is made immediately. Some may think that this is rather harsh treatment. It may be considered so in the beginning, but it is only a matter of a short time until the hospital's policy will become known to the community and you will have very little difficulty with your private accounts.

"To some of us the greatest miracle, repeated every day, is that we can live at all in surroundings which our ignorance and neglect create."—Florence Nightingale.

"Our grand business is not to see what lies dimly at a distance, but to do what lies clearly close at hand."—Caryle.

READING—A DOCTOR'S PRESCRIPTION IN THE HOSPITALS OF ST. PAUL

A LONG the trail blazed by the public library of Sioux City, Iowa, in supplying a steady and ever-lengthening line, Lakeside Hospital at Cleveland, a large Toledo institution, the Mayos at Rochester and many more are installing circulating libraries.

Among the pioneers in this field, which is new in civilian life but tested in war, the Public Library of St. Paul claims second place. Modelling its service after the Sioux City group system and enlarging and adapting it to fit local conditions, the hospital extension work of the St. Paul library has been functioning actively since March.

Miss Perrie Jones, hospital librarian at St. Paul, writes both helpfully and entertainingly of the early struggles and achievements of library service in the hospitals of that city and by frequent intimate flashes of dialogue and description shows what a boon reading may be to patient, doctor and nurse. Following are excerpts from Miss Jones' reports to the Amherst H. Wilder board of the hospital service of the St. Paul library:

"With 2,000 hospital sick in the city the question first off was: What should be the source of the 3,000 or 4,000 books from which the patients must draw? To take that number directly out of circulation from the public library would cripple very decidedly the service being rendered the community. So to avoid robbing Peter to pay Paul, we decided upon a book week. These six days, February 14-19, we advertised through the press, pulpit, by means of various publicity 'stunts,' and by direct appeal through clubs and meetings. The result was more than 4,000 books, about 3,000 of which were bedside material.

"As far as we could see there was only one fly in the ointment and that was the matter of carts to take the books from ward to ward and from bed to bed. Of course the whole value of this work rests not upon *books* in hospitals (that has existed for years), but upon *reading* in hospitals which is only possible through personal distribution of books. We needed ten carts and for a time advanced no farther than to the point of estimates, blue prints, hearings, committee meetings, personal interviews and expressions of interest and sympathy.

"In April the city council honored our requisition for seven carts, two were donated by individuals, and the tenth was procured by Maj. Gardner for Public Health Service Hospital No. 65 from the War Department. That takes care of all the hospitals and greatly facilitates the work.

"It is a matter of growing satisfaction to see the interest the doctors are taking in this matter of reading for the sick. The first day at M. P. Hospital I was stopped

any number of times by attending physicians who wanted to know what it was, this traveling library. Without exception they expressed enthusiasm for the idea.

"Of course, it is medicine for them, the best kind of thing. 'Why hasn't it been done long ago?' was a general question.

"After it had been started it seemed such an obvious thing to do, of course. Here was a reading public of 2,000 who needed books and yearned for them, but who couldn't go where books were. With some, perhaps, it was their only opportunity to read.

"In any of the hospitals all it is necessary to show the book cart and the nurses come flocking.

"'Can you let me have this?—and this?' they ask.

"Others stop me with 'Don't forget 127' or '124 wants especially to see you.'

"We felt like journeymen tinkers dispensing our wares.

"At first they occasionally asked, 'Is there any charge?'

Or as a lovely white-haired old lady from Sweden said, 'Hur kostet det?' When I said, 'Ingenting,' she answered with an eye to a bargain, 'Well then, I must certainly take it.'

"One powerfully built son of the North woods, with brooding eyes and the groping mentality of a child, as a result of a severe nervous breakdown, attracted my attention. The first time I saw him, feeling that there would not be much response, I simply said, 'Here is a good book for you,' and put it in his hands. 'L'right,' he growled, his frightened eyes following me suspiciously. The next

time I found that he wanted above everything else a Buffalo Bill story. So I got it and now we have chats. He actually chuckles if the West is mentioned often enough.

"As a means of extending the library idea to the heterogeneous public I can think of no better agency than that of book service in the hospitals. We have daily evidence of its providing diversion and actual instruction for many who would otherwise live hour after hour with nothing to do but think of their miseries. One woman said to me, 'You know the last time you came in and left me a book, I didn't see what I could want of anything like that, I was in such pain. But I picked it up and actually could not put it down, and I forgot all about being ill.'

"That was what nice, amusing 'Martha-by-the-day' could do for one sufferer. A nerve patient in the same room took a book rather just because it was being done, as she assured me she had read practically everything in the library. She wanted something more, most decidedly, the next time the books came around. Can you think of what it must mean to a deaf and dumb patient to be supplied with books in the hospital? Such a case we found at St. Paul's the other day.



Taking medicine from books at a St. Paul hospital.

"Then of course, one often encounters the morose sick, usually a man, who more or less growls, 'Nope—never read.' Then, as he catches sight of the cart and books his curiosity is aroused. 'Well, what have you got?' he will ask, and very probably takes the first book he is shown. He settles himself back with 'Guess I might read that' with growing surprise at himself and things in general.

"There is a growing feeling, I think, that there is a very definite place in all hospitals for reading. It is not unusual now to have the floor nurse tell you, 'Dr. B—wants you to get this patient of his to read if you can.' The doctors' orders now frequently contain a prescription for reading.

"Books are being given to the service regularly and the

public shows a steady interest in the work not only by gifts of reading material but by requests for us to address clubs on the work.

"At the American Hospital Association convention at West Baden last autumn we were very cordially given space for any exhibit we might have and were sent the credentials of a full-fledged delegate. Unfortunately I could not leave but sent the exhibit consisting of posters, photographs and explanatory material. This I learned could not be exhibited inasmuch as no exhibit was shown without its sponsor on the ground. Another time some one must go and explain this phase of hospital work. It is a coming idea the arrival of which is not very far off."

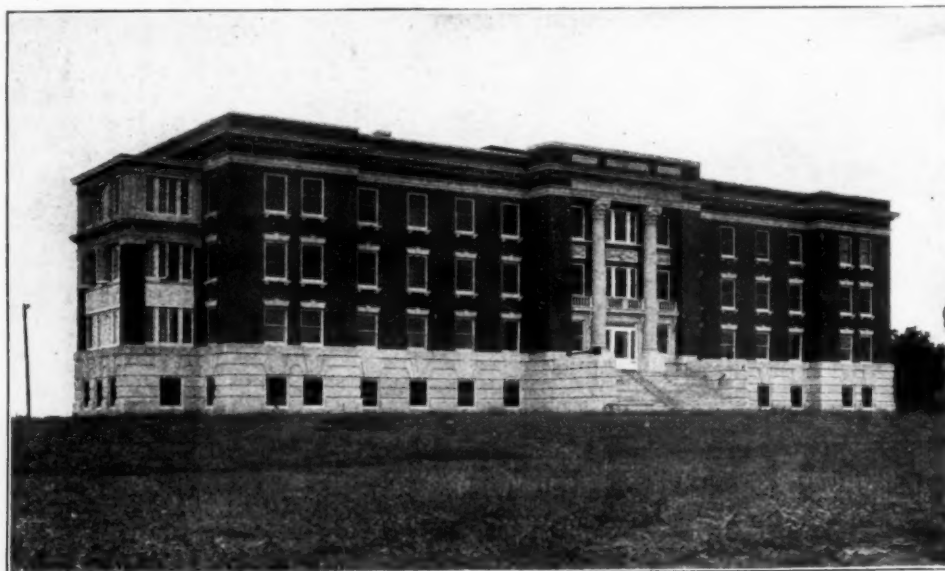
ORGANIZATION OF McPHERSON COUNTY HOSPITAL*

BY L. F. QUANTIUS, M.D., McPHERSON COUNTY HOSPITAL, McPHERSON, KANSAS.

THE organization of McPherson County Hospital was first made possible through the real fellowship of the physicians of McPherson which created a spirit of cooperation that the entire county was finally made to feel. This fact made it easier to present the matter of a county hospital to the citizens.

Our old hospital which was a stock organization had made an enviable record with the few conveniences it had. When the state legislature enacted a law permitting counties to build hospitals, each physician appointed himself a committee of one to present the matter to the people. The Kansas law, which is given below, explains how it is possible to build and maintain a hospital and training school for nurses, with equal rights to all

specify in the petition the maximum amount of money proposed to be expended in purchasing or building said hospital, such board of commissioners shall submit the question to the qualified electors of the county at the next general election to be held in the county or if no general election shall be held within six months from the date of the presentation of said petition, then at a special election called for that purpose, if requested in the petition, which tax shall not exceed two (2) mills on the dollar for any one year and be for the purchase of a site or sites and the erection thereon of a public hospital or hospital buildings, and for the support of the same; which said election shall be held at the usual places in such county for electing county officers, the vote to be canvassed in the same manner as that for county officers. The board of commissioners of such county shall submit to the qualified electors thereof, at a regular or special election, the question of whether there shall be levied upon the assessed property of such county a tax of mills on the dollar for the purchase of real estate for hospital purposes, for the construction of hospital buildings and for maintaining same, or for either or all such purposes. The ballots to be used at an election at which the hospital question is submitted shall be printed with a statement substantially as follows: 'For a mill tax for a public hospital and for the maintenance of same.' If a majority of the votes cast at such election on the proposition so submitted shall be in favor of a mill tax for public hospital



The \$250,000 hospital built and operated by McPherson County, Kansas.

and privileges to none in a county of forty thousand or less.

"Any county having less than forty thousand inhabitants may establish a county hospital in the following manner: Whenever the board of commissioners of any county shall be presented with a petition, signed by twenty-five per cent of the resident free holders of such county, ten per cent of whom shall not be residents of the city, town or village, where it is proposed to locate such public hospital, asking that a tax may be levied for the establishment and maintenance of a public hospital at a place in the county named therein, and shall

*Paper read before the last meeting of Kansas State Hospital Association.

and for maintenance of the same, the board of commissioners shall levy the tax authorized, which shall be collected in the same manner as other taxes are collected and credited to the hospital fund, and shall be paid out on the order of the hospital trustees for the purpose authorized by this act and for no other purposes whatsoever.

"Appropriation for the improvement and maintenance in counties exercising the rights conferred by this act, the board of county commissioners is hereby authorized to levy a tax each year in addition to tax for hospital fund hereinbefore provided for, not to exceed one-half mill on the dollar, on all the taxable property of said county for the improvement and maintenance of any public hospital so established, such tax to be levied and collected as other taxes."

The advantages of a county hospital over a sectarian hospital are evident. When one is a patient in a de-

nominal hospital, he is ever cognizant of the fact that he is receiving care through the kindness of some benevolent organization. Almost unconsciously the patient senses this. On the other hand the community or county hospital is the people's own institution and it has an atmosphere about it that bids one welcome.

We are accustomed to the practice of hospitals being built and equipped by cooperative interests. We know such institutions have filled a most needed place. Their contributions, however, are as nothing compared to the services which county hospitals may render.

When we launched our hospital project we first presented the situation to a sympathetic ear in each township and made sure that our township representative understood clearly the advantages of such an institution to the community. We also provided him with an influential citizen as a helper in securing the names of voters he was to interest. Our campaign thus begun was rushed to completion, and when the votes were counted, exclusive of those from the city of McPherson, there was a sufficient majority to carry the project.

The cost of our construction was \$152,000. The equipment, which was the best we could obtain, cost \$98,000, making a total of \$250,000. The number of lives saved, based upon the commercial value of human lives, would already have almost paid for the institution, I am convinced. Although the above figures seem huge, communities should have the best equipment and laboratory facilities possible.

We have a fifty bed hospital with private rooms only, a toilet and lavatory to each room. The ground floor has a splendidly equipped kitchen, cold storage, laundry, water softener, storage rooms, nurses' cafeteria and dining room. The medical department is on the first floor, the obstetrical department on the second with the preparation room, birth room, and nursery; the surgical department on the third with two operating rooms, anesthetic room, sterilizing room, blanket warmer, physicians' dressing room equipped with shower, physicians' scrub-up room, nurses' scrub-up room, x-ray, bacteriological, pathological and chemical laboratories. Live steam is supplied to our sterilizer, blanket warmer, utility rooms, and main kitchen. Each floor has a large solarium on the south end of the building, and a diet kitchen and refrigerating plant are on each floor. The administrative part of the building, the kitchen and the laundry can readily take care of fifty more beds should the addition be required.

The fact that our hospital board is composed of laymen (physicians in active practice are prohibited from serving on the board) keeps the institution in the laymen's hands; for this policy the medical profession of our county is most grateful.

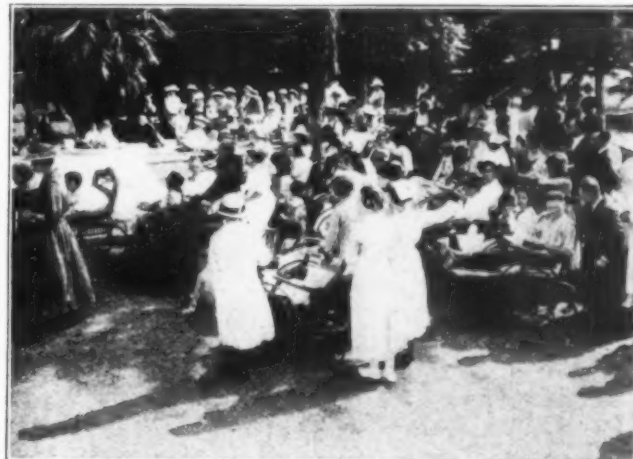
We feel we have hospital accommodations that would be impossible in a county of our population, under any other plan of building and maintenance, and that a fellowship is promoted among its physicians, that is of the greatest value to the community. Our men have an opportunity for special work along different lines making a more efficient hospital staff than is possible under the usual hospital management.

"With God's blessing he will recover" is a common form of speech with people who, all the while, are neglecting the means on which God has made health or recovery to depend.—Florence Nightingale.

The vocation of every man and woman is to serve other people.—Tolstoi.

THEATER COMES TO PATIENTS

Because several hundred patients of a Los Angeles hospital could not go to the theater, the theater came to them. The occasion of the unusual *en masse* movement of a complete theatrical performance was July 4 which gave



Underwood and Underwood.
The hospital lawn's a stage.

promise of being a dreary affair for the shut-ins. The actors brought their entire show to the hospital lawn, and patients such as could be moved out of doors on wheel chairs, were able to watch the performance as well as the main floor of the theater.

DISINFECTION IN 1766

Dr. Thomas Bond in delivering one of his lectures to medical students on November 26, 1766 discussed current methods of disinfection and isolation as follows:

"I lately visited an Irish Passenger Vessel, which brought the People perfectly healthy untill they came in our River. I found five of them Ill, and others Unwell, & saw that the Fomes of infection was spreading among them. I therefore ordered the Ship to Lay at Quarantine, to be well purified with the Steams of Sulphur, & with Vinegar, directed the Bedding & Cloathing of the People to be well wash'd & Air'd, before any person should be permitted to Land out of her, after which I advised separating the Sick from the Healthy.

"This was done by putting twelve in different Rooms in one House, & fourteen in another, out of the City, the conveniences of the two Houses were much the same, in one of them little care was taken of the Sick, who were laid upon the same foul beds, they (contrary to orders) brought on Shore with them; the consequence was, that all the Family catch'd the distemper, & the Landlord Died. In the other my directions were Strictly observed, the Sick has clean Clothes, & clean Bedding, were well attended and soon Recovered, without doing the least injury to any person that visited them; which confirms my observations I had often made before, that the Contagion of the Malignant Fever lies in the Air confined & corrupted, by a neglect of Rags & other filth about the Helpless Sick, & not from their Bodies."

"Probably no person ever did that well which he did only for money. Certainly no person ever did that well which he did not work at as hard as if he did it solely for money. You never yet made an artist by paying him well. But—an artist ought to be well paid."—Florence Nightingale.

(Continued from page 209.)

WHAT THE SMALL HOSPITAL PAYS ITS SUPERINTENDENTS						No. of Beds	Sex of Supt.	Monetary Salary	Monetary Equivalent of Maintenance	Amount of Last Increase	Date of Last Increase
(Continued from page 209.)											
No. of Beds	Sex of Supt.	Monetary Salary	Monetary Equivalent of Maintenance	Amount of Last Increase	Date of Last Increase						
28	F	150.00				*40	M	200.00	40.00	50.00	Jan., 1922
30	F	150.00	25.00			40	F	101.00	40.00	9.00	June, 1920
*30	F	100.00	65.00			40	F	125.00	60.00		
*30	F	150.00	25.00	25.00	Jan., 1922	40	F	175.00	40.00		
30	F	150.00	40.00	16.66	Jan., 1921	40	F	130.00	50.00	15.00	June, 1921
†30	F	100.00	40.00	12.00	1920	40	F	100.00	40.00	25.00	Jan., 1921
30	F	100.00	50.00			*40	M	150.00	40.00	25.00	May, 1922
30	F	125.00	56.00			†40	F	200.00			
30	F	100.00	50.00			40	F	125.00	50.00	25.00	Oct., 1918
30	F	125.00	56.00			40	F	175.00	40.00	16.66	Oct., 1920
30	F	100.00	25.00			40	M	180.00		20.00	Dec., 1921
30	F	150.00	50.00			40	F	110.00	40.00	15.00	June, 1920
30	F	130.00		Reduced \$50		†40	M	216.66	41.66	41.66	Oct., 1920
30	F	150.00	50.00			40	F	125.00			
30	F	100.00		25.00	June, 1919	40	F	130.00		5.00	Oct., 1921
30	F	130.00		10.00	Jan., 1922	40	F	150.00	50.00	25.00	Jan., 1920
*30	F	150.00	25.00	25.00	Jan., 1922	40	F	125.00	75.00		
30	F	90.00	25.00			40	M	125.00			
30	F	150.00	40.00	25.00	1920	40	F	175.00	50.00	50.00	July, 1920
30	F	100.00	35.00	25.00	1919	40	F	150.00		42.00	Jan., 1920
30	F	125.00	35.00	25.00	Sept., 1921	†40	M	300.00			
30	F	150.00	18.00			41	F	150.00	60.00	25.00	Oct., 1921
30	F	100.00	40.00			42	F	150.00	37.50		
30	F	150.00	50.00	25.00	June, 1920	42	F	150.00	40.00	25.00	Jan., 1922
†30	F	100.00	10.00	25.00	Jan., 1922	*44	M	150.00	50.00		
†30	F	200.00		50.00	Jan., 1920	†45	F	150.00	40.00		
*30	F	300.00	60.00	50.00		45	F	125.00	40.00	25.00	1921
†30	F	150.00	40.00			†45	M	225.00	30.00	25.00	June, 1921
*30	F	125.00	50.00	25.00	Aug., 1920	45	F	125.00		25.00	1920
*30	F	125.00	30.00			45	F	125.00		25.00	1920
*30	F	135.00	40.00	10.00	July, 1921	*45	F	150.00	60.00	25.00	May, 1921
†32	M	150.00		20.00	June, 1920	46	F	125.00	30.00	25.00	July, 1920
32	F	125.00	30.00	10.00	Feb., 1922	46	F	125.00	75.00	10.00	Oct., 1921
*33	F	150.00		25.00	Oct., 1921	48	M	291.66	41.75	25.00	Jan., 1921
33	F	150.00	40.00	25.00	June, 1920	48	F	150.00	25.00	25.00	Oct., 1920
33	F	125.00		25.00	June, 1920	50 to 74 Bed Group					
34	F	150.00	100.00	25.00	1920	†50	M	180.00		16.00	April, 1920
*34	F	130.00	40.00	30.00		50	F	125.00		15.00	Jan., 1921
34	F	150.00				†50	M	500.00			
35	F	150.00	30.00			50	F	150.00	40.00	25.00	Mch., 1920
35	F	125.00		25.00	Jan., 1918	†50	F	100.00	32.00	20.00	June, 1921
35	F	100.00	40.00	15.00	Oct., 1920	50	F	200.00	65.00	33.00	1921
35	F	200.00	40.00	50.00	Jan., 1921	†50	F	150.00	25.00	25.00	Jan., 1920
35	F	125.00	40.00	25.00	Jan., 1921	50	M	100.00	40.00	5.00	April, 1922
35	F	150.00	40.00			†50	F	160.00	40.00	35.00	1921
35	F	125.00	40.00	10.00	July, 1921	50	F	150.00	40.00		
35	F	185.00	40.00	25.00	1919	50	F	200.00	60.00	50.00	May, 1921
†35	F	125.00	40.00	25.00	April, 1920	50	F	150.00	50.00	25.00	Oct., 1921
†35	F	75.00	40.00			50	F	90.00	50.00	10.00	1916
35	F	100.00	25.00	20.00	Aug., 1919	*50	F	175.00			
35	F	150.00	25.00	30.00	July, 1921	†50	F	125.00	40.00		June, 1920
*35	F	125.00	50.00	25.00	Oct., 1920	50	F	125.00			
35	F	125.00	40.00	25.00	1918	50	F	150.00	35.00	25.00	1919
35	F	100.00	28.00			50	F	125.00		15.00	Jan., 1922
*35	M	125.00	40.00			50	F	200.00		50.00	Nov., 1921
35	F	165.00	40.00	15.00	June, 1922	50	F	125.00		25.00	April, 1922
35	F	150.00	40.00	15.00	Mch., 1922	*50	F	208.33	75.00	41.66	Jan., 1920
*35	F	165.00	50.00	16.00	Nov., 1921	50	F	125.00	50.00	25.00	Jan., 1921
35	F	175.00	75.00	37.50	Jan., 1921	50	F	150.00	36.00	25.00	April, 1922
35	F	125.00	40.00	12.50	Jan., 1922	50	F	125.00		25.00	Jan., 1921
35	F	125.00	65.00	25.00	Jan., 1920	50	F	100.00			
35	F	150.00				50	F	125.00	25.00		
35	F	125.00	75.00	25.00	June, 1920	50	F	125.00	50.00		
*35	F	125.00	40.00	25.00	May, 1921	50	F	125.00			
35	F	100.00				50	F	125.00		Bonus	
†35	F	150.00	65.00	15.00	July, 1921	50	F	150.00		50.00	Jan., 1921
36	F	125.00	41.66	25.00	Jan., 1920	50	F	150.00	20.00	25.00	Jan., 1921
*36	F	100.00	49.00			*50	F	200.00	49.00	100.00	Jan., 1919
36	F	175.00	75.00			50	F	150.00	40.00	13.00	1920
†37	F	150.00		25.00	Jan., 1921	50	F	175.00	50.00	25.00	1921
38	F	125.00	20.00	15.00	1919	50	F	200.00	80.00	50.00	Oct., 1921
†39	F	150.00		25.00	Oct., 1921	50	F	150.00	50.00	25.00	Oct., 1921
40	F	100.00				50	F	100.00	50.00	25.00	Nov., 1919
†40	F	175.00	30.00	25.00	1918	50	F	150.00	41.66		
†40	M	125.00	40.00	25.00	Feb., 1921	50	F	150.00	56.00		
40	F	140.00	40.00	15.00	1921	50	F	125.00	40.00		
40	F	145.00	25.00			50	F	200.00	50.00	25.00	1920
*40	M	101.00	40.00			50	F	150.00	25.00		
40	F	200.00	60.00	50.00	Oct., 1921	50	F	125.00	50.00		
*40	F	125.00	40.00			*50	M	175.00	50.00	50.00	1918
40	F	125.00	40.00	25.00	1918	50	F	200.00	60.00		
40	F	150.00	40.00	25.00	1919	50	F	125.00	40.00		

No. of Beds	Sex of Supt.	Monetary Salary	Monetary Equivalent of Maintenance	Amount of Last Increase	Date of Last Increase	No. of Beds	Sex of Supt.	Monetary Salary	Monetary Equivalent of Maintenance	Amount of Last Increase	Date of Last Increase
*50	F	150.00	35.00	25.00	April, 1921	†60	M	166.00	50.00	33.00	1919
50	F	150.00	30.00	25.00	June, 1920	60	F	150.00	50.00	12.50	Nov., 1920
*50	F	100.00	40.00	15.00	Jan., 1920	60	F	150.00			
*50	F	250.00	40.00			60	F	125.00	30.00	25.00	Mch., 1922
50	F	160.00	40.00	20.00	June, 1922	60	F	165.00	40.00	16.00	June, 1920
50	F	125.00	40.00	25.00	May, 1921	60	F	175.00	40.00	25.00	Jan., 1921
50	F	125.00	40.00			*60	F	125.00	40.00		
50	F	125.00	75.00			60	F	150.00	40.00		
*50	F	125.00	15.50	15.00	June, 1920	60	F	150.00	8.50		
50	F	100.00	40.00			60	F	160.00	50.00	10.00	Jan., 1922
†50	F	175.00	50.00	50.00	Jan., 1922	†60	F	250.00	40.00	75.00	July, 1920
50	F	166.00	41.00	25.00	May, 1922	60	F	110.00	40.00	10.00	Jan., 1922
50	F	150.00	40.00	50.00	1920	60	F	150.00		25.00	1921
†50	F	100.00	25.00	25.00	June, 1919	60	F	125.00	30.00		
†50	M	150.00	44.00			†60	F	125.00	75.00	50.00	June, 1917
50	M	150.00	55.00			60	F	200.00	40.00	50.00	April, 1922
50	F	130.00	40.00	30.00	Jan., 1922	60	F	150.00	83.00	25.00	Jan., 1919
50	F	150.00	50.00	50.00	Jan., 1921	†60	M	208.00		68.00	1920
50	F	125.00	40.00			60	F	110.00	50.00	10.00	Aug., 1920
†50	F	100.00	40.00			†60	F	175.00	40.00	25.00	June, 1921
50	F	130.00	40.00	10.00	1921	62	F	292.50	25.00	141.66	Mch., 1922
50	F	150.00	40.00	15.00	1921	†62	F	135.00	40.00		
50	F	125.00	40.00	25.00	May, 1922	64	F	200.00	10.00	50.00	July, 1922
50	F	160.00	40.00	25.00	June, 1921	64	F	150.00	75.00	20.00	Jan., 1922
50	F	100.00	130.00	25.00	Oct., 1921	65	F	225.00	60.00	25.00	April, 1922
†50	M	125.00		25.00	1915	†65	F	150.00	50.00		
50	F	125.00	38.00	25.00	1918	65	F	150.00	34.00	25.00	May, 1920
50	F	110.00	50.00			65	F	175.00	75.00	25.00	June, 1921
50	F	166.00	40.00	15.00	Sept., 1921	65	F	125.00	50.00	25.00	Feb., 1922
†50	F	200.00	Board	25.00	Jan., 1920	65	F	150.00	42.00	25.00	Oct., 1920
†50	F	125.00	75.00	25.00	1919	†65	F	150.00	30.00	25.00	July, 1919
50	F	125.00	40.00			65	F	150.00	40.00	25.00	Aug., 1920
*50	M	200.00	43.00			65	F	175.00	25.00	25.00	Nov., 1921
50	M	125.00	25.00	16.00	Jan., 1921	65	F	100.00			
50	F	115.00				65	F	175.00	42.00	50.00	Aug., 1919
50	F	150.00	40.00			†65	M	210.00		20.00	Jan., 1921
50	F	125.00	22.00			*65	F	200.00	65.00		
50	F	125.00	30.00			†65	M	250.00		25.00	Jan., 1922
50	F	125.00	50.00			65	F	150.00	40.00	25.00	Nov., 1920
50	F	166.00	40.00	25.00	Sept., 1921	65	M	300.00	40.00	50.00	1919
51	F	125.00	50.00			65	F	150.00	50.00	15.00	Jan., 1922
†52	F	200.00	30.00	25.00	Jan., 1922	†65	F	225.00		60.00	Jan., 1922
†52	F	120.00	40.00	20.00	1919	65	F	150.00	75.00	25.00	July, 1921
52	F	166.66	40.00			*65	F	165.00	70.00	25.00	Aug., 1920
52	F	165.00	50.00	15.00	Oct., 1921	†66	F	83.00	12.00	16.60	Dec., 1920
52	F	150.00	40.00			†67	F	125.00	40.00	25.00	June, 1921
†52	F	250.00				67	F	150.00	20.00		
52	F	125.00	40.00	15.00	Oct., 1920	†68	M	166.00			
52	F	125.00	35.00	25.00	Feb., 1921	68	F	150.00	44.00	2.00	Mch., 1921
52	F	150.00	40.00			68	F	150.00	90.00	25.00	Nov., 1921
†54	M	200.00				68	F	175.00	75.00	25.00	May, 1920
54	F	133.00	40.00	16.00	1919	70	F	200.00	40.00		
54	F	150.00				70	F	100.00	40.00	20.00	Sept., 1919
54	F	175.00	43.33	25.00	Dec., 1921	†70	M	300.00		50.00	May, 1921
55	F	150.00	40.00	25.00	1921	70	F	150.00	50.00		
55	F	150.00	40.00	25.00	Sept., 1921	†70	M	100.00			Jan., 1920
55	F	166.00	40.00	41.00	Feb., 1922	†70	F	100.00	50.00	25.00	Aug., 1920
55	F	250.00	83.33	50.00	Mch., 1922	70	F	175.00	40.00	25.00	Nov., 1920
55	F	125.00				70	F	150.00			
†56	F	150.00	30.00	41.00	Jan., 1921	†70	F	175.00	60.00	150.00	1919
56	F	140.00	50.00	10.00	1921	†70	M	150.00			
56	F	150.00	45.00	25.00	April, 1921	*70	F	125.00	180.00	40.00	Oct., 1920
57	M	275.00	50.00	25.00	Jan., 1922	†70	M	200.00	60.00		
†60	M	300.00	25.00	50.00	Jan., 1922	70	F	140.00		15.00	Jan., 1921
60	F	100.00	40.00	10.00	1920	†70	M	250.00	25.00		
60	F	125.00		25.00	Jan., 1928	*70	F	165.00	50.00	15.00	Oct., 1919
60	F	150.00	50.00	25.00	June, 1921	70	F	150.00	40.00	16.00	May, 1922
60	F	166.66		16.66	Dec., 1921	70	F	150.00	40.00	16.67	April, 1920
†60	M	150.00	40.00	25.00	July, 1921	70	F	100.00	40.00	25.00	1921
60	F	141.66	33.33	25.00	Jan., 1922	†70	F	120.00	40.00		
60	F	125.00	41.66	25.00	Jan., 1921	70	F	100.00		80.00	
60	F	166.66	40.00	41.66	1918	70	F	125.00	40.00		
*60	F	200.00	83.33			72	F	150.00	58.00	25.00	Jan., 1921
*60	F	150.00				72	F	75.00	40.00	25.00	Jan., 1918
60	F	150.00	58.33			75 to 99 Bed Group					
60	M	283.33	160.00	58.33	Mch., 1922	75	F	150.00	30.00		
†60	M	283.33		41.66	1917	75	F	200.00	78.00	50.00	June, 1921
†60	M	300.00				75	F	125.00	25.00		
60	F	110.00	25.00			†75	F	150.00	27.00	22.00	1920
†60	F	135.00	40.00	10.00	Nov., 1921	75	F	150.00	60.00		
60	F	175.00	40.00	25.00	Jan., 1922	†75	F	140.00	40.00	15.00	Jan., 1922
60	F	150.00	40.00	25.00	Jan., 1922						

No. of Beds	Sex of Supt.	Monetary Salary	Monetary Equivalent of Maintenance	Amount of Last Increase	Date of Last Increase	No. of Beds	Sex of Supt.	Monetary Salary	Monetary Equivalent of Maintenance	Amount of Last Increase	Date of Last Increase
75	F	125.00	35.00	25.00	July, 1921	†90	M	200.00	30.00		
75	F	200.00	35.00	25.00	May, 1922	90	F	200.00	40.00	25.00	Mch., 1921
75	M	165.00		20.00	May, 1920	90	F	125.00			
75	F	167.00		42.00	Jan., 1921	92	F	175.00	60.00		
75	M	270.00		Reduced \$27	Feb., 1922	93	M	250.00	42.00		
†75	F	200.00	40.00	25.00	1920	*93	F	100.00	32.00	16.66	1920
75	F	150.00	40.00	25.00	1921	95	F	100.00		80.00	April, 1921
75	F	190.00	50.00	10.00	July, 1921	95	F	200.00	50.00	25.00	Mch., 1921
†75	F	125.00	30.00			96	F	110.00	40.00	20.00	May, 1920
†75	M	250.00		75.00	Jan., 1922	97	F	130.00	40.00	15.00	June, 1921
75	F	100.00									
75	F	150.00	25.00	25.00	1919						
75	F	125.00	40.00								
75	F	150.00	40.00								
75	M	150.00	50.00	50.00	1921						
75	F	150.00	40.00	25.00	1918						
75	F	150.00	30.00	25.00	May, 1922						
75	F	75.00		15.00	Aug., 1921						
†75	M	200.00		30.00	Jan., 1922						
†75	F	125.00	40.00	25.00	Aug., 1920						
75	F	200.00		25.00	Dec., 1920						
†75	F	100.00	75.00	25.00	1918						
†75	F	150.00	30.00	25.00	Nov., 1919						
75	F	166.00		42.00	Oct., 1920						
75	F	175.00	50.00	25.00	June, 1921						
75	M	125.00		25.00	Feb., 1921						
†75	F	400.00	100.00	100.00	Jan., 1921						
75	F	150.00		25.00	1920						
75	F	150.00	30.00	25.00	Aug., 1920						
75	F	200.00	70.00	50.00	June, 1920						
75	F	200.00	40.00	25.00	June, 1920						
75	F	190.00	55.00	25.00	Jan., 1922						
†75	F	125.00	25.00	25.00	June, 1922						
76	F	125.00	40.00	25.00	1920						
76	F	200.00		50.00	1919						
†79	F	125.00	41.00	41.00							
†80	M	200.00	66.00	25.00	May, 1922						
80	F	150.00	50.00	25.00	Oct., 1920						
†80	M	416.00	12.00								
†80	F	200.00	125.00								
80	F	116.00	48.72								
†80	F	125.00	35.00	25.00	1921						
80	F	166.00	40.00	16.00	Jan., 1921						
80	M	458.00	40.00								
†80	F	166.00		66.00	Mch., 1919						
†80	F	150.00	40.00	10.00	July, 1920						
†80	F	250.00	40.00	100.00	May, 1920						
†80	M	225.00									
80	F	175.00	42.00	25.00	Jan., 1922						
80	F	150.00	30.00	25.00	Aug., 1920						
*81	M	200.00	90.00	25.00	Jan., 1922						
82	F	150.00	40.00								
*85	F	185.00		35.00	Mch., 1921						
†85	F	150.00	40.00								
†85	M	300.00									
85	F	175.00	35.00	25.00	Jan., 1922						
†85	M	250.00	60.00	50.00	1920						
85	F	125.00	40.00	25.00	Sept., 1920						
85	F	175.00	25.00	25.00	May, 1919						
*86	M	200.00	90.00	25.00	Jan., 1922						
†86	M	300.00									
86	F	125.00	40.00	25.00	1920						
†86	F	250.00		50.00	Jan., 1920						
†86	M	375.00		50.00	Jan., 1922						
†86	F	150.00									
†87	F	250.00	40.00	50.00	1918						
†88	M	250.00		42.00	Oct., 1921						
90	F	125.00	42.00								
90	F	150.00	33.00	25.00	May, 1921						
90	F	175.00	25.00	25.00	Sept., 1921						
†90	F	175.00	40.00	25.00	Mch., 1922						
90	F	124.00									
†90	F	200.00		50.00	Aug., 1921						
90	F	100.00	40.00	25.00	1919						
90	F	175.00	40.00								
90	F	150.00	40.00								
90	F	150.00	40.00								
90	F	150.00	50.00								
90	F	150.00	41.66	16.66	April, 1921						
*90	M	125.00	40.00								
†90	M	225.00		50.00	Jan., 1920						
90	M	416.66	60.00								

ADEQUATE SYSTEM OF GARBAGE DISPOSAL

Food waste in the hospital will continue until an adequate system of garbage disposal is instituted, writes C. J. Decker, superintendent of the Toronto General Hospital. The installation of such a system is not difficult nor does it require expensive equipment. Each unit must, however, be provided with a standard garbage can of adequate size. These cans must be collected daily or oftener if necessary and their contents weighed and recorded. This work should be handled by a man who is chosen not simply because he will engage in that type of work, but rather because he feels the importance of the work he is doing and will take an interest in it and render accurate reports. These reports should reach the superintendent daily and they should get the attention due them.

In smaller hospitals the head nurse of each unit should be told of the result of weighing the waste coming from that unit daily and any fluctuation should be discussed. In large institutions charts should be provided showing the per capita waste for each unit; these should be distributed at least once a month and the superintendent should comment in writing on the results in each case. I am satisfied that this system will reduce food waste in your hospital. Any sudden rise in the edible waste will usually indicate a defect in the quality of the food bought or fault in preparation. Heavy garbage usually means one of two things, either that the patient is being served too much food or food for which he has no desire. This will be determined through the procedure I have just outlined; if it is found true, then a system should be inaugurated that will prevent the serving of food not desired by patients.

SEEK NEW SANATORIUM SITE

Convinced by city engineers and officials that the construction of a tuberculosis sanatorium near White Pond, N. Y., would contaminate the water supply of the city of New York, the Constructive Jewish Aid Society has given up its proposed sanatorium site and is seeking another location. Sites under consideration are at Tupper Lake, another near Saranac and a third on Long Island. At a hearing before officials of the state department of health, it was brought out that White Pond is a part of the Croton watershed and that the erection of a sanatorium there would jeopardize the city water.

Many lives and much property are lost every year because of accidents due to venereal diseases, says the U. S. Public Health Service. So great in fact are these losses that the National Safety Council has issued a bulletin on them. For instance, four serious recent railway wrecks were traced to employees who failed because they were suffering from paresis, which is a form of syphilis.

THE WORK OF THE SOCIAL SERVICE DEPARTMENT OF A STATE HOSPITAL

By AARON J. ROSANOFF, M.D., LOS ANGELES, CAL., FORMERLY CLINICAL DIRECTOR, KINGS PARK STATE HOSPITAL, KINGS PARK, LONG ISLAND

THE Kings Park State Hospital has over 5,300 patients, nearly 800 employes and twenty-two resident medical officers. It is located at a distance of forty-five miles from Brooklyn, whence it receives the great majority of its 1,000 to 1,200 annual admissions. One of the senior assistant physicians has been detailed on whole time to have charge of the social service department, which consists of six women social workers, one male attendant detailed as a social worker, two stenographers and a transportation agent.

The greater part of the work of the social service department is in connection with the hospital's parole system, which has been greatly extended during the past three years, as the following figures show.

On January 1, 1919, there were 288 patients on parole. On December 11, 1921, this number had risen to 889, the highest point in the rather long history of the hospital.

Further extension of the parole system of this hospital can undoubtedly be brought about, but for the time being its development is being delayed by the prevailing hard times and unemployment, which affect not only the patients but also their relatives and friends who, in better times, might be able to cooperate with the hospital by assisting the patients.

The social workers attend all staff meetings at which cases are presented for parole. In some cases, prior to granting parole, they visit the patients' homes or prospective places of employment and secure information which helps to decide whether parole be granted and, if so, to whose custody and under what conditions.

The usual parole period is one year, during which time the patient reports once a month at one of the out-patient clinics conducted at the Eastern District Hospital, Brooklyn, N. Y., every Thursday morning and evening, and at the Nassau Hospital, Mineola, L. I., every Monday afternoon. Two physicians and two social workers are in attendance at the clinic.

In case of a patient failing to report at the clinic personally, by letter or by telephone, he is visited by a social worker either at his home or at his place of employment. For convenience in such visiting the Borough of Brooklyn has been divided into districts, these being assigned to the different social workers.

A continual record is kept of each patient on parole, in which are included reports of his condition, work, etc., as observed from time to time, usually once a month, at the clinic or on occasions of the social worker's visits, or as they are made known to the hospital by letter or by telephone. Sometimes the custodian of the patient or a relative reports for him at the clinic or by letter. These reports constitute the basis of any after-care measures that may be undertaken: change of custodian, securing new employment, providing medical treatment at out-patient clinic, returning from parole, re-paroling for another year, etc.

In assisting patients to attain a social adjustment extra-murally the social service department often has the cooperation not only of relatives or prospective employers, but also of such organizations as the Board of Child Welfare, the Red Cross, the Department of Public Wel-

fare, the City Employment Bureau, and private charities.

Although a large proportion of the patients released on parole since the inauguration of the extended system in this hospital have chronic psychoses of many years' standing and recovery in a medical sense is quite out of the question in their cases, yet, with the aid of our social service department, they have been helped to a social adjustment such as has made them not only self supporting but also, in some instances, successful to the extent of producing a surplus to put away in the bank or to help their families.

As an important by-product of the activities of the social service department may be mentioned an educational influence among relatives, friends, and employers of patients, charitable organizations, and others, leading to a more rational and more helpful attitude toward the so-called insane and a correction of traditional misapprehensions, prejudices and fears.

Among other activities of the social service department are to be mentioned the following:

(1) Field work on families of patients with general paralysis or other syphilitic conditions. Relatives of such patients are brought to the out-patient clinic for medical examination, including the Wassermann reaction, and, if found to be syphilitic, which happens in 15 to 20 per cent of the cases, are advised to put themselves under treatment, such treatment being offered them gratis if they cannot arrange for it otherwise.

(2) Obtaining case histories from patients' relatives or friends who come to the hospital and, where necessary, verifying and supplementing such histories by field investigation.

(3) Making all required psychometric tests both in cases admitted to the hospital and in those treated in the out-patient clinics.

(4) Assisting in research work carried on in the hospital.

From a financial standpoint it can readily be shown that a state hospital can no longer afford to conduct its operations without the aid of a social service department. The saving in the maintenance of chronic patients amounts to many times the cost of maintaining such a department.

But the matter should be regarded not only from that standpoint, but also, and mainly, from the standpoint of the general gratification and benefit accruing to the patients, their relatives, friends, employers and all others concerned. This manifests itself in an unmistakable improvement in morale both in the hospital and within the entire sphere of its influence.

The discussion of pros and cons of a special social department and an extended parole system in a state hospital cannot be entered upon here. The reader is referred, instead, to previously published contributions on this subject.*

*Mary C. Jarrett: *Applications of Sociology in Psychiatry*. Manual of Psychiatry, edited by A. J. Rosanoff, fifth edition, 1920—A. J. Rosanoff and T. S. Cusack: *Parole System and Its Relation to Occupational Therapy*, *Amer. Journ. of Insanity*, Oct., 1920—W. C. Garvin: *How the Number of Parole Patients Was Increased at the Kings Park State Hospital*, *N. Y. State Hospital Quarterly*, Nov., 1920—G. W. Mills: *The Activities and Uses of a Parole Clinic*, *N. Y. State Hospital Quarterly*, May, 1921.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
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MENTAL HYGIENE IN ITS RELATION TO PRESENT-DAY NURSING*

BY L. VERNON BRIGGS, M.D., DIRECTOR, MASSACHUSETTS SOCIETY OF MENTAL HYGIENE, BOSTON.

WHAT confronts the sufferer from mental disease today is, first, the difficulty of finding a physician who is educated in the care and treatment of mental sickness, and, second, the difficulty of securing the services of a nurse who has had experience along these lines. Generally these difficulties are so great and the patient's needs are so urgent that the only avenue of escape is for the family to send him to a private sanitarium for mental diseases or to a state hospital. And even in these special hospitals, in many of which we have skilled medical attendance, it is at present often impossible to provide adequate nursing.

It is not possible to separate mental hygiene from hygiene in general. Our mental and physical functions are so closely interwoven and so mutually interdependent that they cannot be regarded separately. The problem of nursing the mentally sick is not that of caring for the frankly insane (as they are still erroneously called)—nor for the feeble-minded—nor the nursing of raving maniacs or imbeciles—but of the care of large groups of individuals whose physical symptoms find their origin in poor mental adaptation, in personality defects, in factors in the environment, or in mental peculiarities due to subtle toxic conditions which can only be determined by the psychiatrist through the constant observation of highly trained and intelligent nurses. Where is there a nurse who would refuse to take a case of typhoid fever or of puerperal conditions of chronic interstitial nephritis with mental disturbance, and yet these disturbances do not differ materially from those of the so-called insane, whom the same nurse would probably decline as patients. This attitude is not to be wondered at, for as Thom very aptly reminds us it is only a few years—perhaps ten—that psychiatry has been associated with general medicine. But now we meet with conditions requiring mental nursing not only in the special hospitals for mental diseases and in the community, but in its general hospitals, in the industrial field and in the schools, where nurses skilled in mental hygiene are to take their place in the field of preventive medicine.

There are two things I want to impress upon you, first, I want to disassociate the idea of training in mental nursing from that of the care of the so-called insane or "crazy"

people; that is an infinitesimal part of your work as a nurse. It has been said that the brain is like a good piano badly played upon. Mental disturbance requiring the most skilled nursing may often be the result, not of a defective or diseased brain, but of disease of some particular organ of the body, forming toxins which in the circulation play upon the brain and produce mental symptoms. Secondly, to have mental nursing one of the required subjects in your training would not mean that you were to be relegated to state hospitals. It would only mean that you were to get there a part of your training which will enable you to better take care of mental disturbance no matter in what form it may appear.

Few people, even among the medical profession, have any idea of the prevalence of mental and nervous diseases. Do you realize that in Massachusetts in the year 1920 one out of every 20 adults who died in the entire state died in a state hospital for mental disease and twice as many enter and leave the hospital as remain to die there? This means that one out of every ten of our adult population is at some time during his life a patient in a hospital for mental and nervous diseases. And this is not taking into account the unrecognized cases, the neglected cases and the cases receiving treatment in their own homes! How many of these deaths from mental disease might have been prevented by early recognition and intelligent nursing! Certainly training in mental nursing is proportionately more important than training in obstetrical or surgical nursing. And yet not one general hospital training school in the state requires any training in the care of mental cases.

Mental Nursing Not in Curricula

The situation in the state at the present time in this branch of work is deplorable. It is with great difficulty that a physician can obtain the services of a nurse trained in the care of the mentally sick. The difficulty is so serious that many patients are sent to state hospitals who might be nursed in their own homes away from surroundings suggesting mental illness. Why is this so? The usual answer made by the nurse is: "They are difficult cases. We should we take them when we already have more than we can do with the medical and surgical cases?" That is not really the reason. I do not believe that nurses train for their profession to the end that they may pick and

*Read before the League of Nursing Education of the Massachusetts State Nursing Association, February 18, 1922.

choose the easy or agreeable cases. To be sure, nurses now specialize in surgical work, in obstetrical work, or typhoid or tuberculosis cases, but that is after they have received their general training and have registered. The undergraduate does not prepare specially for any one branch of nursing any more than the undergraduate physician devotes himself to a single specialty. It is not possible for either of them to know whether they are going to be more efficient in one branch of the service than in another until they have had the general training upon which all the rest is based. All specialties are interdependent.

Now what is most regrettable is the fact that most training schools for nurses do not require the study of the care of mental and nervous diseases, but leave these subjects entirely out of their curricula. The nurses, therefore, not only lose the opportunity to find out whether they are specially adapted to this important and profitable branch of the service and would like to choose it for a life work, but they are deprived of what should be an important part of their training for general nursing, and a large class of patients are left without the service which all nurses should be able to give. For one of the strongest reasons for including mental hygiene in the education of nurses is that it would be of value to every nurse to be able to apply the principles of the care of mental and nervous cases to her every-day patients. There is scarcely a patient to whom a nurse is called today who has not an element of mental or nervous instability, especially when mind and body are weakened. A lack of education along these lines makes the case much more difficult for the average nurse. Society is like a complicated machine made up of millions of parts, and the members of society with mental troubles are defective parts of that machine which prevent its working smoothly. But they cannot be scrapped like the defective parts of a machine merely because they clog the social machinery, for they are human beings. They generally feel themselves to be out of adjustment and suffer accordingly, for by the law of our nature we can only be happy when we are filling our normal place in the scheme of things. The intelligent nurse helps to repair these defective units that they may be replaced in that part of the social machine where they are best able to function.

It is a great satisfaction to help bring the unsettled mind back to normal and it requires a much higher training than to assist in the cure of physical ills. The mind is more interesting than the body to study, to treat and to nurse.

Opportunities in Mental Nursing

A nurse thoroughly trained in mental health work in all its branches has one of the greatest opportunities for service that can be given to anyone, opportunities which may be extended into the families and homes of her patients and into the community at large. The day is not far distant when she will become a teacher of mental health in the family and in the community. It is the nurse who, in a great measure, will be responsible for starting the child on the road to mental stability, and the training which a nurse can give to a child from birth, and especially during its school life may make success or failure when that child enters society and has to face the obstacles and competition of adult life.

Education in mental health, in addition to enabling the nurse to understand and handle her patients much better than she would otherwise be able to do, would also enable her better to handle herself in the presence of nervous and apparently unreasonable patients. Few nurses

today know enough of mental hygiene to conserve their own nervous energies by taking proper care of themselves so that they are not unnecessarily irritated and fatigued by these trying cases whose behavior in illness varies from the normal standard. These conditions a nurse with suitable training in mental hygiene should meet successfully and cheerfully. Those who have had this training have a storehouse of reserve force which they may call upon under the most trying circumstances. The lack of mental training is a real neglect in the nurse's education and shows a want of appreciation of the needs of the patient and of the nurse herself, as well as of the trend of the ideals for which she is working.

The nursing in our mental hospitals today is gradually improving, but it is still far from satisfactory. Recently, in addressing a committee, I made a statement that we should have a higher grade of nurses in our state hospitals for the mentally ill; that, as a whole they were not up to the standard of general nurses, though I stated that among them there were many who were well-trained and efficient and whose services were invaluable. No words can express the appreciation and gratitude of the patients and of their families and friends for what some of these devoted women are doing. It is to be hoped that the time is not far distant when their associates will be given equal training and that the highly specialized and often most interesting work in our mental hospitals will be done by nurses, trained or in training, who are equally faithful and intelligent. But I added in my statement to the committee that we have many so-called nurses and attendants in mental hospitals who are ignorant, lazy, and stupid, a floating population of low-grade individuals, who know little and care less about the scientific nursing and humane care of these mentally ill people. This remark of mine was somewhat misquoted in the newspapers, and I was criticized by one of the leading members of your profession for having attempted to overthrow the morale of the nursing schools in the state hospitals, which are struggling against long odds to establish high ideals without much support or encouragement from the nursing profession in general. This critic has not appreciated the fact that I was attempting to enlist the support of this committee for constructive measures to raise the standard of nursing and to educate better the student who has chosen to devote her life to the amelioration of suffering.

There was no higher call during the war—there is no higher call today in time of peace—than that of the nursing profession. But this is a call to help all who are ill and suffering. There is no class of patients who can be benefited more by tactful and intelligent nursing than the mentally ill, for a large portion of mentally nervous disorders are curable and all can be benefited by proper care and treatment. There is no class of patients for whom the physician alone can do so little and the nurse so much; in many instances the doctor is helpless without the nurse. No two cases are alike, few can be early classified, and the call for quick decision, tact and initiative on the part of the nurse is much greater than for any other type of disease.

There is no class of patients so large today as that of the mentally ill; mental diseases call for more nurses than all other diseases put together, for there are more beds for mental patients in the hospitals of the United States today than there are in all our general medical and surgical hospitals added together. So have not we, who are working in the cause of the mentally ill, a right to ask that nurses be educated in the care and treatment of nervous and mental patients as well as of other patients,

and has not the nurse, who gives several years to her professional training a right to demand that her education be rounded out and completed, that she may take her place with these patients as well as with those suffering from other ills?

The demand for nurses with psychiatric training is more than doubling each year. If nurses are not given this training how are we to supply the demands of the industrial plants, the hospitals, the courts, the charitable organizations, the schools and the community? Every public school requires a nurse with psychiatric training, and the demand is always likely to be greater than the supply. Indeed so great is the necessity for a better understanding of mental problems in the schools that it is safe to say that we must go farther and not only demand that school nurses have psychiatric training, but we shall very soon also require that our teachers shall have some knowledge of psychiatry and mental health and include these subjects as a part of the curriculum of every normal school and college. The number of students who break down under the present courses of study is alarming. It is well for the nurse to understand one or two of the causes which play an important part in the breaking down of our present-day society. I will mention two that have been pointed out by two great men.

Two Causes of Mental Disorders

First, the great Italian, Bianchi, emphasizes among other things the stabilizing effect of work on the mind and deplors the prevailing conception that the fewer hours we have to work, the better off we are. He says, "This is the view which politicians and labor leaders—to promote their own selfish interests—are impressing on the public. The result is that the shortening of the hours of labor, instead of giving leisure for home duties and family life, is deteriorating character and mental health, as the free hours are devoted to loafing. "Work," he says, "the great stabilizer of the nervous system, is abhorred and shirked more and more—a sad perversion of the ideal aimed at in the early agitation for the eight-hour day."

The great French authority, Pierre Janet, declares that the present day society has another factor to contend with, which results in the breaking down of many minds and the resort to alcohol, drugs, etc. He says:

"I have already had occasion to point out in this connection a type of mental overwork that is typical of the age in which we live. The philosophic ideas in regard to the equality of man have brought to a common level the ambitions of all classes. They have subjected all minds, no matter what the caliber, to efforts that our fathers never thought of making in the same manner. A dramatic author once said: Several generations are required to make a minister out of a janitor's son.

"If we could make the social struggle less severe; if we could check the desire to attain social position too rapidly, and if we could discourage dangerous ambitions, could we not unite what now seems irreconcilable: freedom of thought and tranquility of beliefs? These are great questions and more closely linked to the problem of alcoholism, and also that of race suicide, than is commonly supposed."

The dictum that "All men are equal," a mistranslation of the "right of all men to an equal opportunity," on which our democracy is based leads many to strive to compete much beyond their mental and physical strength. The result of instilling this idea that all are equal to shouldering responsibility or reaching equal heights into the minds of those who are not stable, who are not gifted with the power to compete with their fellows, is that they

are forced to the front and encouraged to take positions and responsibility they never should take. They fall by the wayside one after the other, some sooner some later, and many of the patients today in the hospitals are the victims of this application of the democratic idea. They have believed that all men are equal mentally and physically, only to find too late that they have limitations which should have been recognized early in their lives. And here is another field for the properly educated nurse who has daily contact with the unstable child or adult; she should be able intelligently to size up their limitations, and at least in the case of the child, help him to avoid the fatal result of too great ambition, and later the assumption of too great responsibilities.

Prejudice Is Based on Superstition

The difficulty in interesting nurses to take training in mental health is due in the first place to prejudice—to the prejudice of the nurses themselves and the community at large—against these unfortunates. This prejudice dates back to the dark ages when the mentally afflicted were supposed to be possessed by evil spirits and were tied to the pillars of the churches and whipped by the priests, whipped to drive the devils out of them. It was this tradition which later led to the abuse of the mentally ill in their homes and in institutions, for whipping had been allowed by the churches and towns were permitted to chain these poor unfortunates in the almshouses and prisons, so why should not ignorant attendants punish and maltreat them? Even in comparatively recent times, these people have been treated not as patients but as dangerous malefactors, relegated to almshouses and prisons where they could do no harm with no thought of the harm that was being done them. That prejudice, itself based on superstition, prevailed all over the world, and its influence is still felt by the nurses of today. And why not? Has stress been laid during the training of these nurses upon the fact that the brain is only one of the many organs of the body, which can become diseased the same as the liver or lungs or kidneys? Have they been told that diseases of the brain are the same in medical importance and no more hopeless of cure under proper medical and nursing care than diseases of any of the other organs of the body?

The brain is the most highly developed organ of the body and its diseases call for the most scientific nursing. The study of the care of mental illness requires a higher intelligence and education than of tuberculosis of the lungs or disease of the kidneys, etc. because we have in the brain not only a possible physical condition in a very complex organ, but a psychic condition. Those who treat these cases most understanding not only the organic brain but its functions, its variations from normal and its susceptibility to environment. A large portion of cases of so-called brain disease show no sign of disease at autopsy. It is in this large group of cases that the study of the individual and his environment rather than of the brain must be made and the treatment and care directed accordingly.

Psychiatry is such a deeply interesting study that once a physician really enters the realm of mental medicine he rarely leaves it for any other branch. In fact I know of no man who has ever left the practice of psychiatry for any other specialty after having gone into it deeply enough to understand what it means. I believe it would be the same with the nurse, and that if nurses should voluntarily make the study of mental nursing a part of their curriculum, or if it should come to be a required subject, many would be found who would choose it for

their life work because the field is so tremendous and so interesting and they can accomplish so much good.

There is one important point which must not be forgotten in speaking of the desirability of education of nurses in mental health work, and that is the benefit to the thousands of patients in our state hospitals—state hospitals for mental diseases today, but state hospitals for mental health tomorrow. These hospitals are greatly in need of nurses with skill and scientific training, and their training schools will undoubtedly develop to meet the demand which is bound to come for training affiliates from the general hospital training schools as well as the demand for post-graduate courses for registered nurses.

The whole number of nurses and attendants employed in the ward service of our state hospitals wholly in the department of mental diseases for the year ending Nov. 30, 1921, was 1,464.76, and increase of 211.67 over the previous year. There were seventy-two graduates only in this group. There were 3.61 rotations in this group compared with 4.18 rotations the previous year, and the average length of the interval between rotations was 3.35 months, as compared with 2.90 months the previous year.

Affiliations With General Hospitals

The affiliations in our state hospitals are as follows:

Institution	Nurses graduated in 1921	Affiliations
Worcester Hospital....	13	Boston City Hospital.
Taunton Hospital....	13	12 months' service at Boston City Hospital.
Northampton Hospital	5	12 months' course at State Infirmary, embracing surgery, diseases of children, obstetrics and gynecology.
Danvers Hospital....	6	Bellevue and Allied Hospitals.
Westborough Hospital	4	Massachusetts Homeopathic Hospital, 1 year's instruction in surgical, gynecological, obstetric and pediatric nursing.
Boston Hospital.....	17	Boston City Hospital, 12 months' training in contagious diseases, obstetrics, operating room technique, general medical and surgical.
Psychopathic Hospital	0	No training school.
Grafton Hospital.....	9	Boston City Hospital.
Medfield Hospital....	4	(Female) Bellevue and Allied Hospitals.
Gardner Colony	0	.....
Monson Hospital	1	Bellevue and Allied Hospitals.
Foxboro Hospital	0	No training school.
Mass. School for Feeble-minded	0	No training school.
Wrentham School	0	No training school.
Bridgewater Hospital.	0	No training school.
	72	

While the foregoing table represents the affiliations, one must not be led to believe that the affiliation is mutual. For not one of these general hospitals sent to the state hospitals, to which they are affiliated, any pupils.

A second reason why we find it difficult to get good nurses for mental cases is that the education of the physicians themselves has been neglected. It is only within the last year that psychiatry has been made a required subject in Massachusetts medical colleges, and a law has been passed making it obligatory (beginning in 1923), for all physicians to pass an examination in psychiatry before they can register to practice in the state. It is no wonder that physicians have done so little in mental medicine when they have not been trained to recognize mental diseases, and they have naturally not expected their nurses to understand mental nursing. Now that psychiatry

is an important part of the physicians' training, the younger men, at any rate, will be demanding nurses competent to look after their patients. It is part of the program for preventive medicine.

Psychiatry in State Examinations

Another important part of the program to meet present-day medical needs is that, as physicians are obliged to pass an examination in psychiatry, so nurses must qualify in psychiatric nursing before they can register to practice in the state. This training would give the nurse a better chance to deal successfully with her cases, mental and physical. It would make her one of the "sentinels of mental health," as Donald Laird puts it, and help to afford an opportunity for psychiatrists, who now concentrate their efforts upon institutional cases, to turn their attention to the community and become real hygienists.

The physicians, newly awakened to the importance of mental disease, and especially the young general practitioner who has himself been trained in psychiatry, will demand that his nurse shall at least know how to observe and report early mental symptoms and care for incipient cases of mental disease, often preventing their further development. This is a very important branch of mental hygiene, and no one has a larger part to play in it than the well-trained general nurse, if she has the vision to rise to the occasion and be prepared to meet the call which is already becoming more and more urgent. The future development of mental hygiene, not only in private practice but in public health work, in the school, in industrial medicine and in the community, is assured. Is the nursing profession ready to rise to this demand, or will it be necessary to create a new profession to meet it? If the leaders among our nurses demand both undergraduate training in psychiatric nursing for all general nurses and postgraduate training for teachers and specialists, there is little doubt that the hospitals will meet them half way and furnish it.

I believe that an exchange affiliation of the general hospitals with the state hospitals would be of great mutual benefit, furnishing in both general and mental hospitals more intelligent nursing care. In the state hospitals it would be the greatest encouragement to the faithful and efficient nurses now on duty. Our fourteen state hospitals graduated in the year 1920 only seventy-two pupils out of an average daily ward service of about 1,465.75 including nurses and attendants. These state hospitals have some affiliations with general hospitals, but the general hospitals send no pupils in exchange for those who go to them for training in obstetrics, etc. It is a crime and a blot on our civilization that patients in mental hospitals have not long ago been placed on the same basis of medical care and nursing as patients in our general hospitals. When the history of the state hospitals is finally written, an intelligent community will wonder how the present staffs of medical men and nurses have accomplished so much in the care and treatment of the patients, handicapped as they have been. They certainly should be awarded distinguished service medals for having held the fort for so many years before the arrival of reinforcements.

I have permission from the Rockefeller Foundation to tell you that in a report on "The Education of Nurses in this Country" which they are soon to publish, they recommend that all nurses shall have a course in mental hygiene, including at least three months in hospitals for mental diseases allied to general hospitals, before they

receive their diplomas. This is a great step, and unless I am mistaken, no recommendation made by the Rockefeller Foundation along the lines of medical work or improvement has failed to be favorably acted upon.

Summary

1. Psychiatry is no longer confined to asylums, prisons, almshouses. It is now one of the foremost problems of social and preventive medicine and is playing its part in educational, industrial, judicial and military organization.

2. Mental illness does not mean so-called insanity. Mental symptoms are frequently part of the picture in typhoid fever, puerperal conditions, autointoxication, and results of poisonous substances taken from without into the body.

3. Psychiatry and psychiatric nursing deal with the individual as a whole rather than with some particular organ.

4. The final analysis in every case, whether it be medical, surgical, obstetrical, or what not, has a mental aspect which needs to be taken into consideration.

- a. The suicides of chronic invalids.
- b. The marked depression seen in cardiac and nephritic cases.
- c. The exaltation of the hyperthyroid cases also seen frequently in tuberculosis.
- d. The delirium of typhoid fever.
- e. The confusion and mental deterioration seen in brain tumors.
- f. The hallucinations seen in toxic conditions.

These are all part of the picture produced by the inevitable mixture of mental and physical conditions.

5. The mental atmosphere of the home can be best studied by the nurse. It is she who comes into most intimate contact not only with the patient and the immediate members of the family, but frequently she acquires a most intimate knowledge of the patient's personal life including his worries, anxieties and the problems which he has to meet. With training pertaining to the mental health of patients the nurse can render reports which would be invaluable to the physician or surgeon in his task of making differential diagnoses. Hysteria, for example, may assimilate any symptom from the category of medicine and it is only after a long period of observation by one who is familiar with mental reactions that these symptoms can be intelligently interpreted.

6. I do not appeal to you to enter the field of neuropsychiatric nursing on the basis of any altruistic motives nor do I hold out at this time any economic advantages which might result by entering this field. Rather would I lay stress on the fact that it is your duty as members of one of the noblest professions to neglect no opportunity to fit yourselves to render the best that is in you. Without knowledge of the mentality, personality and individuality of your patient this cannot be done. You are being deprived of an opportunity to determine for yourselves whether or not you have a special interest and leaning toward psychiatric nursing and you are also deprived of the reward and the satisfaction that comes from success in nursing a damaged personality back to health and happiness.

There are two requisites in a superintendent (of nurses): 1. Character and business capacity. 2. Training and knowledge. Without the second, the first is of little avail. Without the first, the second is only partially useful; for we cannot bring out of a person what is not in her."—Florence Nightingale.

ENTERING THE PROFESSION OF NURSING

May I now address a few brief remarks to you, the graduating nurses of the Springfield General Hospital, who will be admitted tomorrow to the real responsibilities of the independent practice of your profession? You have heard flattering statements about the fitness of women for this important work. You have been culled and eliminated by a careful natural selection until only the fittest of your original class remains. You have withstood the strenuous drilling, the exacting routine, you have become educated in the fundamentals of scientific medicine and the art of caring for the sick. You have been subjected to the example of efficient and ethical teachers. You have learned by long hours of work under trying circumstances to govern your own desires; to hold in abeyance a tactless tongue and possibly an ungovernable temper. You have watched from the sidelines the many developments of the follies of human nature, the struggles of poverty and the depths of moral depravity. You have been in the midst of tragedies, of adventures and of romances. You have seen death and hopeless sorrow and you have seen the ecstatic joy of the mother at her new born babe. As I enumerate this list, in the minds of all of you are reenacted scenes and experiences that would fill a volume of the most transcendent material of romance and adventure, the knowledge of which must surely build the strongest characters.

This knowledge and this experience have been gained under the guidance of anxious and conscientious teachers, who have ever been able to advise and to assist.

The period of probation is now over. You are at the first altar and, like the bride, you have before you the responsibilities of real life, and it is for better or for worse.

Remember that knowledge brings responsibility and that experience makes or breaks one's character.—Extract from a graduating address delivered at Springfield (Mass.) General Hospital by Franklin H. Martin, M.D., Director-General, American College of Surgeons.

LEAVES AKRON CITY HOSPITAL

H. G. Yearick has resigned his position as superintendent of the Akron (Ohio) City Hospital. He relinquished his duties on September 1. Mr. Yearick went to Akron in May of 1919 from Spokane, Wash. where he was superintendent of St. Luke's Hospital. During his regime, a new pavilion was added to the Akron City Hospital, increasing the capacity of the institution to 225 beds, and the hospital was recognized by the American College of Surgeons as a Class A institution.

"A nurse should do nothing but nurse. If you want a charwoman, have one. Nursing is a specialty."—Florence Nightingale.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Supervising Dietitian, Mt. Sinai Hospital, New York.

POPULARIZING THE USE OF CERTIFIED MILK*

By FRANK HOWARD RICHARDSON, M.D., CHILDREN'S DEPARTMENT, BROOKLYN HOSPITAL, BROOKLYN, N. Y.

IT WAS brought home recently to the members of the Milk Commission of the Medical Society of the County of Kings, New York, that their whole duty had not been accomplished when they provided the community with a healthful milk, and certified to its healthfulness. They came to feel that they owed it to the community to spread this knowledge much farther than it had ever yet been spread.

Accordingly, a special committee was appointed recently and charged with the task of bringing about a wider use of certified milk. The committee promptly reported its conviction that the only way to accomplish this aim was to popularize the prescription of certified milk by the physicians of the borough. The dealers, as all of us know, have always asserted that the sale of certified milk depends upon its prescription by the doctors; so that this report embodied no new discovery. It did seem worth while, however, to try to analyze the psychology underlying the peculiar fact that people need a doctor's prescription to persuade them to buy the best grade obtainable of the most important item in their dietary, when these same individuals would never for a moment consider buying second grade butter, eggs or meat.

There seemed to be two points of special interest in this connection. The first was the fact that the term "Grade A" seemed to most people to imply that the milk they were purchasing was of the highest grade obtainable; and that "certified," as it could not be better than the best, must be some fancy or specially processed milk that was of use only for a special purpose, such as infant feeding. The second point, which was believed to have some bearing upon the situation, was the fact that milk is as a rule paid for separately and not included with other items on a butcher's or grocer's bill; and so its price is a matter of universal knowledge. Then too any change in the price of milk is considered matter for newspaper comment.

Must Educate Doctor First

Our task then seemed to narrow itself down to educating the doctors to use certified milk and to order their patients to use it, not only for babies and for sick people, but for well individuals as well. For whereas many doctors, and probably most of the pediatricians, are already prescribing certified milk for their babies,

sick or well, it is well-nigh unheard of for a doctor to urge the use of this grade of milk for healthy adults, irrespective of the economic financial status of the family in question, or to explain to his patients the simple readjustment in the daily dietary whereby this milk could be used at a saving rather than at additional expense, by cutting out superfluous amounts of meat and egg proteins, for instance.

Educating the doctor, however, is not always the simple task that it may seem at first blush. We conceived the task as having two distinct parts. One was to convince the physician by direct explanation, argument, appeal, demonstration—what you will; in other words, to proceed against him by means of a frontal attack. The other was to advance upon him from the flank; or, to change the figure, to hit at him from over the shoulder of his patients. For today a successful campaign of propaganda to reach the doctor must have two distinct phases—one medical and one lay. The latter was designed not primarily to convince the layman that he ought to use certified milk for his own table, for this never yet has been accomplished, but we desired so many laymen to make inquiries of their doctors on the subject that the latter would have to take notice and would be especially open to the direct educational appeal we planned to make.

It had been found in the past that the big certified milk meeting, advertised as such, was rather apt to fail of its purpose. Many men were repelled rather than attracted by the announcement of such a program, even when pictures and "movies" were announced. They feel that they will be regaled with pictures of prize cattle, and stables fitted with the latest fads in tiled walls and individual drinking fountains, and that they know beforehand quite as much of this sort of fancy dairying as they need or care to—and this is quite often a pretty fair diagnosis of such an evening's program.

Accordingly, in the new offensive a different plan was evolved. This consisted first in getting each member of the commission to arrange either for a paper or for a whole evening's program before as many of the smaller medical societies in town as he could approach through any personal connections. These included such organizations as the special societies; the local or neighborhood societies (of which there are a number in the large area covered by our borough); the hospital alumni or ex-intern societies; the medical fraternities; and, of course, the Pediatric Society and the County Medical Society. In

*Read before the American Association of Medical Milk Commission, at the annual meeting held in connection with the annual convention of the American Medical Association at St. Louis, May 22.

order to make these programs or papers as attractive as possible and to avoid the trite and obvious, emphasis was put, for example, upon the value of raw milk in nutrition; the importance of common cleanliness in the food supply; the vitamin theory, its history and its present status; the newer knowledge of nutrition with some of the fascinating work in feeding experiments that have gone to make it up; etc. The nigger in the woodpile in each instance was, of course, that the only way in which one can get clean, fresh, raw milk in our city is to get certified milk.

To drive home the points that might come up in the course of the discussion, as well as to answer with technical correctness some of the hard questions that we hoped might be asked, it was suggested that the expert of our commission be invited to all such meetings, and that at each there should also be present enough of a "claque" from the commission to stimulate a healthful and helpful discussion in case such artificial stimulation seemed necessary in order to make things "go."

A corollary to this program of presenting papers is of course their publication in the local medical press, thus spreading further the message that in the nature of things has a fairly limited hearing in the proportion of the society memberships represented at the meetings.

The next means of approach consisted in getting members of the commission personally to stress, in all their work, both hospital and private, the use of certified milk in all conditions and upon all occasions. Of course, all the members of our commission were already using it, either largely or exclusively, in their own homes. But all found that even among their own patients there were many individuals upon whom they had failed to impress the fact of the overwhelming superiority of this grade of milk over the best grade of pasteurized available.

The pediatricists, who constitute the majority of the membership of our commission, began to find that, while many or most of their bottle-fed babies were on certified milk, it was almost the rule for their mothers to discontinue its use of themselves as soon as they dared; in most cases, as soon as mixed feeding was commenced, or shortly thereafter. A very simple statement of the facts in the case was almost always sufficient to make such parents go back to the use of the better grade of milk. The most effective argument here proved to be that there was no reason that their children should receive milk of a second class or grade, when they were getting eggs, butter and meats of the highest quality. Occasionally it was necessary to explain that even though the milk formula was to be boiled, it was none the less desirable to use the cleanest possible milk to begin with; and that boiling, although it could render a living germ harmless by killing it, could not make dirty milk clean nor supply a vitamin lacking through age of the product.

Prescribing It as a "Spring Tonic"

In consultation work, a simple recommendation of certified milk, with one or two reasons for its prescribing in the place of so-called "tonic" or "alterative" has usually accomplished two things. Of these, the lesser has been the resultant use for the individual case in question. The greater has been the impression made upon the mind of the family physician of the importance laid by the consultant upon its use, and his determination to recommend it himself as an important part of the treatment of future cases of a similar nature.

Recommending its use in hospitals or other institutions has been more or less limited by the very nature of the case; through the suggested supplying of institutions in

cans, instead of in bottles, is a possible way out of this difficulty. Private room patients, of course, can always buy it as an outside item, just as fruit and special dishes are frequently brought in. Lactating mothers in maternity services especially fall under this heading. As Brooklyn Hospital pediatricists prefer certified human milk to certified cow's milk, however, we never recommend its use in any other way—in the feeding of the new-born—than by way of the mother's milk-forming laboratory.

The lay propaganda was organized similarly to cover as wide a field as possible with the realization that its value was to consist not so much in the direct education of the laity at whom it was ostensibly aimed, as in stimulating them to ask questions of their individual doctors. We knew that if this could be accomplished on a large enough scale, these men would be forced in self defense to familiarize themselves with the *status praesens* of the milk situation in the vast metropolitan area in which we live with its peculiarly difficult problems in the matter of purveying milk.

Needless to say, it was not considered wise for very obvious reasons to stress the rather unappetizing details of the production of even the best of pasteurized milk within the area of 100 miles surrounding us from which we draw our supply of milk. None of our commission members felt either wealthy or pugnacious enough to stand the brunt of a suit for libel, as the result of too realistic a discussion of some of the sights that greet the eye of any one looking over the ordinary type of farm, and the commission itself did not consider its funds ample enough to provide protection for any daring member who might have cared to be too vivid in his portrayal of conditions. Besides, there was the very natural unwillingness to anything that might discourage the use, on the part of the public, of any sort of reasonably decent milk, especially if such discontinuance of the use of relatively poor milk were to mean not its replacement by a better grade, but simply a stopping of milk drinking altogether. And, as Dr. Van Derslice said in a paper before this body in 1915: "In furthering the use of certified milk there is and should not be any attempt at climbing up by the pulling down of the commercial product. Certified milk sells itself by its own excellence and superiority."

The simplest means employed in the lay propaganda consisted in explaining to friends, even though they chanced to be patients of other doctors, the advantages inherent in certified milk. Any physician is occasionally asked to recommend a "spring tonic," or "blood purifier," whatever either of these may mean. Certified milk, with two or three reasons therefor, constitutes an excellent answer.

The next means consisted in the utilization of opportunities constantly being presented for health talks in churches, schools, chautauquas, lecture courses, etc. Most doctors feel it a duty to do their share toward the education of the laity in matters of disease prevention and health promotion, and the importance of the best grade of milk obtainable is one of the points that always needs stressing. The members of the commission consider themselves fortunate in having been able to give a great many such talks in the course of the year. Our local Red Cross chapter has for one of its activities the promotion of such health education and maintains a speakers' bureau whose sole object is to put various agencies throughout the community in touch with men who are willing to give health talks. To show that we are quite up to the minute, we need only add that two of our members have been asked to "broadcast" health talks from WJZ, the Newark

station of the Westinghouse. Embracing this opportunity to spread the gospel of certified milk via the ethereal waves, one of them took "Nutrition" while the other elected "Child Welfare." Needless to say, each did his duty by certified milk in such topics as these. We must confess, however, that so far we have not availed ourselves of the opportunities lying open to us in the illuminated sign, nor have we subsidized the public press to popularize our product. We have however not despised the power of printer's ink; for each month a reminder card goes out with the County Society's notice of meeting, with some catch phrase or appropriate legend bearing on certified milk.

In both these campaigns, there were two "talking points," if you will allow the expression, that were specially stressed. The first was, that milk is by all odds our most important food—the only article of diet that may honestly be called indispensable. McCollum has put this more convincingly in his little book, "The Newer Knowledge of Nutrition," than it can be found anywhere else. He shows that it is practically the only food for which no acceptable substitute can be provided with safety. The other point was, that there is nothing wonderful or far above the ordinary in the requirements governing the production of certified milk, that these requirements, in short, are really minimum rather than maximum for the production of an ordinarily safe milk. We have been putting our emphasis, unwisely I believe, upon the wonderfully *de luxe* accommodations provided for the fancy certified herd—the tile or porcelain-lined stables, the individual drinking cups, etc. This particular "selling talk" has gone sadly wide of the mark in convincing the great mass of families comprised in the class that we have wanted most to serve—the class, that is, that considers their children so important that they are willing to make any necessary sacrifice to provide the best for them. Necessary sacrifice, mark you; and they are inclined to consider not as necessary, but as freakish costly fads, some of these refinements and frills that we have been inclined to dwell upon in some of our talks.

The point that we have agreed upon as best suited to bring about an increased consumption of certified milk has been this: That certified milk is nothing more nor less than milk produced as any decent man or woman would wish to produce it for his family and his guests, if he were himself the owner of one or two cows. And conversely, that no other grade of milk, whatever letter of the alphabet be used to designate it (and Grade A does not mean Grade 1, in New York City at any rate, in spite of the fact that most people think that it must), is so produced. What are these very matter-of-fact requirements, that any individual would expect to carry out himself?

1. Cleanliness—clean cows, clean udders, clean utensils, clean hands of clean milkers dressed in clean clothes.
2. Freshness—milk to be delivered to the consumer within twenty-four hours of its production.
3. Health—healthy (non-tuberculous) cows, milked by healthy (non-venereal and non-typhoidal) workers.
4. Sweet-taste—the only milk decent enough to be allowed by law to be sold without some processing or other which alters the taste.

If there is no one of these points which a parent would not consider a minimum requirement—which he or she would be willing to dispense with—then a product which fails in any one of these is not a fitting food to be used on the home table. But we know that in order to cover these minimum requirements it is necessary to buy cer-

tified milk for any other grade falls short, not in one of them, but in several.

Such, in very brief form, are some of the ways in which the milk commission of the Medical Society of the County of Kings has sought to carry out one phase of its duty to the parent society and the community which it serves, namely: that of spreading the gospel of raw, clean, fresh milk throughout that community; and especially throughout that key group, the members of the medical profession. It is hard to estimate what effect this effort has had upon the sales of certified milk; perhaps such an estimate can never fairly be made. But we do know that the word spoken into the air is never absolutely lost, and we confidently believe that even such an unostentatious but persistent campaign as the one that has been outlined cannot fail to accomplish great good to our constituency. Whether a more extensive campaign shall be entered into later, has not yet been decided.

NEWS ITEMS

Dietitians of Ohio have planned meetings for December 6 and March 7 as a part of the coming year's activity in that state. Officers who will lead the Ohio Dietetic Association, organized last October, were elected at the meeting at Dayton, May 9 to 10 as follows:

President, Miss E. M. Geraghty, Lakeside Hospital,



OFFICERS OHIO DIETETIC ASSOCIATION

Above are the new officers of the Ohio Association: Miss Geraghty (upper left), Miss King (upper right), Miss Willson (lower left), and Miss Hyde (lower right).

Cleveland; vice president, Miss Jessie King, Grant Hospital, Columbus; secretary, Miss Irene Willson, City Hospital, Akron; treasurer, Miss Bertha Hyde, City Hospital, Cincinnati.

The following committees have been appointed by the new president of the Ohio association to serve for the coming year:

Program: Chairman, Miss Lulu Winans, City Hospital, Youngstown; Miss Florence Smith, Children's Hospital, Cincinnati; Miss Emma Eggert, Lakeside Hospital, Cleveland.

Membership: Chairman, Miss Sarah Benedict, Miami Valley Hospital; Miss Margaret Plough, Tuberculosis Sanatorium, Cincinnati; Miss Irene Willson, Akron.

Nominating Committee: Chairman, Miss Sara McInnis, City Hospital, Springfield; Miss Florence West, Peoples Hospital, Akron; Miss Bess Gatton, City Hospital, Mansfield.

Cook Book is on Press

The cook book which has been compiled by the Chicago Dietetic Association is being published by the Macmillan Company under the title "A Book of Recipes." The committee has been at work for a year on the book and it is said to be most original in make-up. It will be off the press, according to plans, in time for the annual meeting of the national association in Washington, D. C., October 16-18.

The Chicago Dietetic Association has recently received so many calls for dietitians from hospitals and from dietitians for positions that it has authorized the appointment of a committee to act as a clearing house for such requests. Mrs. E. A. Fischer, 5458 Kimbark Avenue, is chairman of the committee and such requests are being addressed to her.

A field for dietitians is revealed in the recent report of the Jail Survey Committee of the Chicago Community Trust. The report which was curtailed both on account of the short time allotted to it and the limited time members of the committee had to devote to it points out the need of trained dietitians to provide an adequate diet at a minimum cost.

Following the discussion at the May meeting of the Chicago Dietetic Association, relating to the violations of a city ordinance regarding the covering of food in shops, a committee from the association has recently been named to call attention of the Food Inspection Bureau to such violations. Miss Ruth Chambers of St. Luke's Hospital is chairman and irregularities are being reported to her.

New Officers for Alleghany County

The Alleghany Dietitians Society held its annual meeting on June 21 at Mercy Hospital, Pittsburgh. The following officers were elected:

President, Miss Margaret Frotheringham, Mercy Hospital, Pittsburgh; vice president, Miss Emily B. Hall, Western Pennsylvania Hospital, Pittsburgh; secretary and treasurer, Miss Hilda Reinhold, Mercy Hospital, Pittsburgh.

Following the business meeting the society spent a pleasant social evening.

Course for Pupil Dietitians

Walter Reed General Hospital, Washington, D. C., is offering a course for pupil dietitians which promises to be exceptionally fine. The course covers a period of six months, during which time the pupils are given practical experience in the various messes and in the laboratory.

Lectures for the Army School of Nursing, beginning October 1, are open to the students. Among these lectures are courses in diet in disease, physiology and anatomy, and communicable and occupational diseases.

Opportunity to attend some of the meetings of the American Dietetic Association which holds its annual convention in Washington, October 16-18, will be given. Arrangements will also be made for pupils to visit the various bureaus of interest in the department of agriculture, such as the bureau of chemistry, bureau of standards and the department of home economics. Quarters, subsistence and laundry are furnished the pupils, it is announced, in addition to a nominal salary of \$15 a month.

Personal Mention

Miss Bertha Luther is administrative dietitian at the Children's Hospital, Boston. She has charge of the entire food service. Miss Luther was formerly at Cook County Hospital, Chicago. Her assistant is Miss Katherine Lees, who is a graduate of the University of Wisconsin and had student dietitian training at Massachusetts General Hospital.

Miss Margaret Frotheringham, Miss Laura Ober and Miss Kate Helzer, members of the Dietitians' Society of Allegheny County, attended a summer school at Columbia University.

Miss Emily B. Hall recently accepted a position as chief dietitian at the Western Pennsylvania Hospital, Pittsburgh. Mrs. Helen Chase Barcalow accepted the position as assistant dietitian formerly filled by Miss Hall.

Miss Mary L. Rhoads gave up her work at Coatesville Hospital, Coatesville, Pa., to accept the position as dietitian at the Tuberculosis League Hospital, Pittsburgh.

Miss Mary Louise Shaw has been appointed dietitian at the Nassau County Tuberculosis sanatorium at Farmingdale, L. I.

Miss Caroline Kling has resigned her position at Grace Hospital and has accepted a post as dietitian at Hotel Statler, Detroit.

CHICAGOANS ISSUE BIBLIOGRAPHY

The publicity committee of the Chicago Dietetic Association has issued the following bibliography which will be of interest to all dietitians:

- Gillett, Lucy: The Great Need for Information on Racial Dietary Customs. *Journal of Home Economics*, 258 (June) 1922.
- Kuh, Dr. Sidney: The Diet of Nervous Patients. *THE MODERN HOSPITAL*, 18, 457 (May) 1922.
- Sale, H. W., and Skinner, W. W.: Food Flavors: Their Source, Composition and Adulteration. *American Food Journal*, (May and June), 1922.
- Guluck, Addison: A Study of Weight Regulation in the Adult Human Body During Average Nutrition. *American Journal of Physiology*, (April) 1922.
- Berea College Where Every Student Must Work. *Hotel Monthly*, 34 (June) 1922. This is an exceedingly interesting article showing how the study body helps to support itself. The organization of the food department is very much worth the time of dietitians.
- Westlake, William: How to Feed in Summer Camps. *School and College Cafeteria*, (June) 1922.
- Feeding Students for the Priesthood. *School and College Cafeteria*, (June) 1922. Shows the problem involved in diet in a Catholic preparatory school.
- Funk: Dr. Casimir: Science Can Make Margarin Richer than Butter. *American Food Journal*, (June) 1922.
- Lister, Dr. James S. U.: The Influence of Rigid Salt Restriction in the Diet of Chronic Nephritis. *American Journal of Medical Science*, (June) 1922.
- Hardt, Dr. Leo L. J.: Studies of the Cause of Pain in Gastric and Duodenal Ulcer. *Archives of Internal Medicine*, (May) 1922.

Prof. Raymond Pearl of the U. S. Public Health Service has discovered that both the suddenness and the destructiveness of the first flu epidemic coincides significantly with the normal death rate from heart diseases in many American cities. It does not so coincide with the death rate of any other important disorder. The inference is obvious.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

MARKING GOODS IN A HOSPITAL LAUNDRY

BY WALTER T. WILLIAMS, CINCINNATI, OHIO.

RESearch in hospital laundries indicates that a little more attention given to the marking department, with the introduction of system, would save much time and prevent many errors with their resultant confusion. It seems that there is no standard system of locating the identification marks, and it seems that there is no logical plan of assigning marks to persons. In other words, the mark on a personal article may be a name, two or three initials, a series of figures, or a combination of letters and figures; and on a given kind of article this mark may be found one time in one location and another time in a different one.

The marking, as a rule, is either done by a marking machine or by a stamp or stencil, so there is no necessity of discussing the old, slow method of pen-marking. Persons who can mark goods with a pen are so few that even in a small plant a marking machine is necessary.

Use Marked Tapes

In the Cincinnati General Hospital, as told in a previous article, the marking of individual pieces, or personal articles, is done by the respective owners, with the exception of the interns. Each person is given a supply of marked tapes, and these tapes must be sewed on the pieces, in a prescribed place, by the owner. As this plan works well in one hospital, there is no reason for it not working well in others. In order to effect the greatest possible saving of time, if this plan is adopted, one should be sure to prescribe for each article a specific place at which the tape must be sewed.

There should be a specific location on a given article for two reasons: first, in order that when the bundle is opened up in the laundry's marking room, one may quickly find whether all articles bear a mark; second, in order that when the articles are folded the marks may be

seen by the sorter. Sometimes it is necessary to place the mark on the under side of the goods, and in such cases it should be so located that the assorter has only to turn up the edge of the goods at a certain place to see it.

Adopt Schedule to Guide Markers

To be sure that all marks are uniformly located, there must be a schedule to guide the markers. Taking as a basis a marking plan that is used in many commercial laundries, and checking it up with the plan that is used in the Cincinnati General Hospital, I have arranged a schedule that can be used in any hospital laundry, large or small. It will do no harm to the general plan, however, if one sees fit to use different locations for marks, if the general idea of uniformity and accessibility is adhered to.

For convenience, the articles are listed in alphabetical order, regardless of whether they are personal goods or otherwise. While the list is very comprehensive, a few unusual pieces may have been omitted, but in this case one may with little difficulty easily determine a suitable place for the mark and add it to the list.

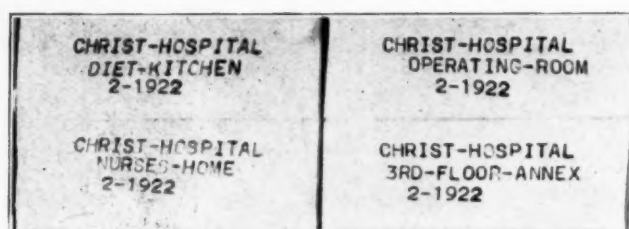
In case of dark goods, or where the fabric is too rough to take a mark, the mark should be made on a tape, placing it at the indicated spot. There is a special sewing machine for attaching tapes, and where this can be afforded it will be found a great convenience. As the marker can

easily determine the cases where it is best to use a tape, I shall not dwell on that matter.

"Wrong side" and "right side," as used in my schedule, are trade terms which respectively mean the side of the goods which is worn on the outside and the side of the goods which is worn on the inside. In the case of flat work the terms refer to the side which is visible and one which is not.



Motor-driven marking machine, from photograph taken in Christ Hospital, Cincinnati. This machine is located in the sewing room, where all marking is done. As the characters are one-fourth-inch high, it is not necessary to use a stamp or a stencil on any goods. "It is the most useful mechanical device in the hospital, and we could not get along without it," said the head of this department, who is shown in the picture.

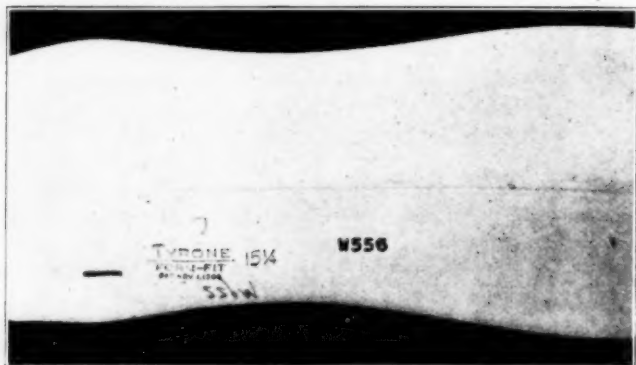


Some of the marks that are used in Christ Hospital, Cincinnati. The mark is placed directly upon white pieces and a label is marked and attached to the dark goods. The letters are one-fourth inch high.

Marking Schedule

Aprons—wrong side, on band.
 Bath robes, individual—wrong side, at neck.
 Bath robes, patients'—at left breast, right side.
 Bags—top, wrong side.
 Bed ticks—at opening, at seam, wrong side.
 Bed gowns, patients'—on left breast, right side.
 Bed pads—on corner.
 Belts—in center, wrong side.
 Bibs—on string, wrong side.
 Blankets—at corner.
 B. V. D.'s—shirts, at back of neck, wrong side; drawers, at back of band, wrong side; union suits, at back of neck, wrong side.
 Coats—at back of neck, inside.
 Coats, surgical—at right breast, wrong side.
 Chemise and combinations—At bottom hem, wrong side.
 Caps, nurses'—on string, wrong side.
 Caps, doctors'—at hem, wrong side.
 Collars—wrong side, near buttonhole.
 Corset covers—at front, on band, wrong side.
 Draperies—on corner, wrong side.
 Drawers—near top button, wrong side.
 Dresses—at back of collar, wrong side.
 Dressing sacques and kimonos—at bottom, on button side, wrong side.
 Fancy pieces—on corner, wrong side.
 Handkerchiefs—in corner.
 Napkins—on hem or selvage, wrong side, in corner.
 Night shirts and night dresses—at top of back of neck, wrong side.
 Operating linen, miscellaneous—on hem or selvage.
 Overalls—trousers, on waistband, wrong side, near button or on pocket; jumpers, or waists, at back of neck, wrong side; bib garments, on bib, wrong side; one-piece garments, at back of neck, wrong side.
 Pajamas—at back, wrong side, below draw string; coats, at back of neck, wrong side.
 Pillowslips—on band, at opening, wrong side.
 Hosiery—at top, over heel, wrong side.
 Sheets and spreads—on wrong side, at corner, at left.
 Shirts—The common method is to place the mark inside of the neckband, at the back. A method which facilitates the assorting is to place the mark on the outside of the neckband, next to the back buttonhole, for then the assorter can see all of the marks on a pile of shirts at one time.
 Skirts—at pocket, wrong side.
 Tablecloths—on corner, wrong side.
 Table pads—on corner, at left.
 Towels, hand and bath—on corner, at left.
 Tray cloths—on corner, wrong side, at left.
 Underwear—shirts, back of neck, wrong side; drawers, on band at back, wrong side; union suits, back of neck, wrong side.
 Vests—at back of neck, wrong side.
 Waists, women's or children's—on button side, at bottom, wrong side.
 Washrags—in corner.

The foregoing applies to machine marks and hand marks. In some cases, of course, very large marks are made in conspicuous places by means of a stamp or stencil, or marks may be woven into the goods as is sometimes done when towels are made. For instance,



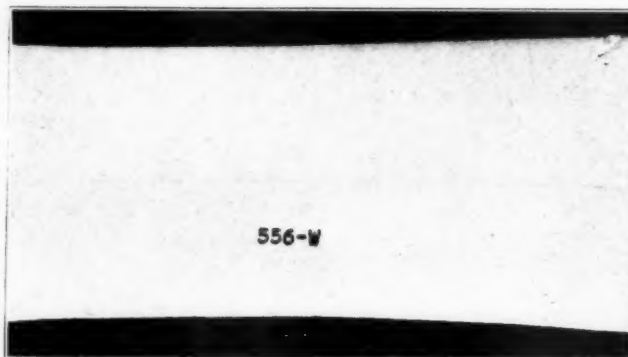
Starched collar with both a machine mark and a hand mark, freshly made, showing the difference in visibility of the two kinds of marks.

if there is a contagious ward, the linen from it will be marked "Contagious," in large letters. Sometimes it will be found convenient to mark linen with the designation of its ward, and in other cases the number of a floor should be used. The marking system, of course, must be in accord with the linen room's distribution system.

It is a good plan to mark on the linen, in addition to the usual identification mark, the date of its first laundering, in order to determine the life of the goods. As has been previously stated, the life of a piece of goods depends on several things, such as natural wear, wear and corrosion of the fiber in laundering, character of the fiber, kind of weave, damage by doctors, nurses and patients, and so on. It is well to find whether the fabrics are lasting a reasonable length of time, and then, if they are not, it is well to find whether the maker, the laundry or somebody else is at fault.

Marks Should Mean Something

Be sure that your marking plan is a simple one. Do not use persons' names or initials, nor abbreviations and combinations of meaningless marks and numbers. Let each mark mean something and not be a mere untrans-



Soft collar, with a machine mark and a hand mark. Although both marks have had about the same number of washings, the hand mark has almost disappeared.

latable hieroglyphic. Such marks as "B. E. M.," "Jones," "Brown-2," "W-562," and so on, are out of place in a hospital laundry. They may do well enough in the commercial laundries, and it may be necessary to use them there, but the use of such marks is neither logical nor economical in the hospital, except perhaps in the case of a sanatorium where it is necessary to do laundering for patients.

In most hospitals, each nurse has a number. In this case, the nurse's number and the designation of her quarters should constitute her laundry mark. Let us suppose that Miss Alice Brown, a nurse, is Number 27, and that she lives in the nurses' home, in dormitory A. In this case her laundry mark should be "27-A," a very simple mark that would tell the whole story.

The same system should be used for the personal washables of the interns and others. The laundry superintendent should secure from the office a list of the names, numbers and quarters of the nurses, interns and other residents of the hospitals. Then a mark record should be made up, assigning to each person a mark. A card index, arranged alphabetically, is best for this.

In some institutions, such as sanatoriums and convalescent hospitals where it is necessary to launder the goods of the patients, it may be desirable to omit permanent marks from the finer articles, especially those which belong to women. Some use marking pins, which



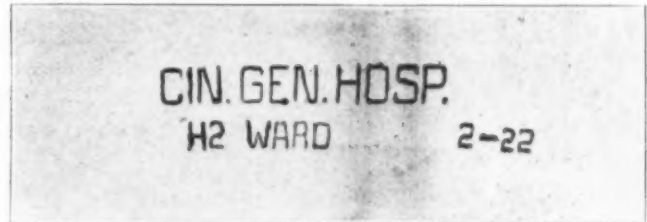
At the left is shown a doctor's mark and a nurse's mark, made directly on the goods. At the right is shown a tape mark sewed on a dark stocking.

are very large safety pins which have numbers on them, but as these are apt to tear the goods, they are objectionable. Here is a very simple plan for attaching a detachable tape:

Cut a piece of marking tape three inches long. Fold it in the middle. Place it in the proper position on the article. Sew the folded tape on the piece, making the seam but one inch long, so as to leave one-half inch of each end loose. One seam in the center will do, but a seam may be made on each side if desired. Mark the tape either before or after sewing it on. When the piece is laundered, the tape may be removed without damage to the goods by taking hold of each end and giving a quick pull which will break the threads of the seam. Do not

use very strong thread. The folded tape may be sewed on one side of the goods, or one side may be under and the other over the goods.

A few illustrations are published herewith, showing the character of the mark and where it should be placed, and



Specimen of mark that is made by a stamping machine used in the Cincinnati General Hospital. The characters in the top line are permanent, these being one-half inch high. The characters in the bottom line can be changed, they being three-eighths inch high.

the legend under each explains it. My next article will show how articles should be folded, and incidentally will say more about the making-up of the marks and the positions in which they should be placed.

HOSPITAL SIGNAL SYSTEMS*

By E. NEWTON-WELLS, SIGNAL ENGINEER, CHICAGO.

Grey Nunnery, Montreal, Canada.—Destroyed by fire February 14, 1918. More than 50 babies burned to death.
State Hospital for the Insane, Norman, Okla.—Destroyed by fire April 13, 1918. Thirty-eight men and boys burned to death.
Hospital for the Insane, Columbia, S. C.—Destroyed by fire May 29, 1918. Ten patients killed and many injured.
Mercy Hospital, Big Rapids, Mich.—Destroyed by fire December 1, 1919. Five killed and three injured.

THE above mentioned hospitals were picked at random from the available records for the past twelve years as typical of several thousands.

If fire protection is warranted in our hotels, factories and schools where physically fit occupants are the rule, how much more necessary is it in institutions used twenty-four hours of each day and filled with the sick and helpless?

The records show that one hospital burns each day, half as many similar institutions are damaged or destroyed each week and the lives of the sick, crippled, blind, and new-born are snuffed out singly, in small groups and occasionally by the score. Nurses bravely risk their lives and remove helpless patients; Sisters of Mercy face death to rescue their charges—these acts prove the heroism of which men and women are capable. The necessity for such bravery lies largely in ignorance, carelessness and criminal disregard of the fundamentals of fire prevention and fire protection.

It is gratifying to know that there are today many institutions which from a fire safety standpoint approach the ideal, but the number of truly safe institutions is small and in the majority of older institutions the conditions frequently are appalling.

The function of this article is to drive home the seriousness of existing conditions and to set forth a few essential facts regarding fire alarm signaling systems which will enable adequate and suitable protection if combined with fire prevention measures.

At all institutions fire fighting must come second to life-saving. In hospitals a safety corps should be or-

ganized composed of doctors, nurses and attendants. The duties of the safety corps should be to respond to all fire alarms, treat and control patients and remove them to places of safety when necessary. All members of the safety corps should be able to turn in a fire alarm properly. The alarm should be transmitted to the superintendent and engineer promptly in order that they or their assistants may use extinguishers on incipient fires, and if occasion requires summon the city fire department.

Because of the possibility of error and delay, the telephone method of sending in an alarm is unreliable and not approved by the Underwriters or the National Fire Protection Association.

Fundamentally the requirements of a hospital fire alarm signal system are much the same in one hospital as in another. Nevertheless, it has been learned by experience that existing conditions create such variations in the details of these requirements that no one particular type of system can be described that will cover the field in general. It is a safe rule where such a system is to be provided to call in a competent signal engineer to go over the institution and lay out a system suitable to the particular requirements.

No hospital building, either old or new, or however well constructed and equipped to resist fire, is immune from fire peril nor from the panic conditions resulting from an imperfectly managed system of removing the patients from the building.

This statement applies to all types of buildings including the modern (so-called fireproof) buildings. Fires among the contents of such buildings have been known to create in a short space of time sufficient quantity of gas and smoke to start a serious panic.

Generally speaking, a modern fireproof building is fireproof so far as the building itself is concerned and would be as difficult to consume in a fire as a modern furnace, but it is possible to have a very hot fire in either. Therefore, the safety of the patients and staff of a hos-

*This article dealing with fire alarm systems is the third in a series on signal systems written for THE MODERN HOSPITAL by Mr. Newton-Wells.

pital building is not guaranteed by the fireproof construction of the building or by means for extinguishing fire, but rather in well arranged exits, efficient training of the safety corps to the end that a small blaze may be quickly extinguished without alarming the patients, or if occasion arises the removal of the patients without confusion or panic.

A study of many hospital fires in the past will show that in many cases the loss of life has been due as much to panic as to the fire itself. Panic conditions are frequently the result of delays in transmitting the alarm and the lack of training of the hospital staff for such emergencies. Panic, destruction of buildings and a heavy death toll may often be prevented by providing well arranged exits, means for extinguishing fire and a systematically trained staff—these things, in my opinion, are best accomplished where modern fire alarm systems are in use.

Fire Alarm Signals

Fire alarm signals should be so given as not to alarm the patients unduly. In many cases it is well if patients do not know that a fire has occurred. Boxes should be located at advantageous points throughout the building, and gongs so placed as to be heard by officials and members of the safety corps.

The system should preferably be of the approved closed circuit fully protected and supervised type, arranged so that an alarm sent in will notify the officials without sounding gongs throughout the building to alarm the patients. This is usually accomplished by the breaking of a glass in the door and pulling the lever down.

Boxes should be fairly large and with semi-flush mounting which are readily seen and their location easily fixed in the minds of the staff. (Small flush type boxes are not to be recommended.) The mechanism should be substantially made, embodying non-interfering dual signal code features.

Boxes and gongs should be on separate circuits connected to the control panel. The control panel should be so arranged that all boxes and gongs are constantly under electrical supervision so that the slightest interruption to the electrical current, or any disarrangement to the box or bell circuits, will immediately cause an alarm to be sounded on the trouble bell located on the control panel. The control panel should be equipped with necessary voltmeters and ammeters in order to ascertain the condition of the circuits and electrical current at all times. The power used for operating should preferably consist of one or two sets of storage batteries charged from the lighting circuit, and should be of sufficient size and capacity to insure the operation of the system for at least twelve hours in the event of failure of the lighting circuit.

When an alarm is sent in from one of the boxes it should be received in code form on a punch register and tapper bell located in the superintendent's office and engineer's quarters, the code giving a definite location of the box pulled. Upon responding to the alarm if the fire is found to have gained such headway as to warrant the calling of the fire department, the door of the box is opened, which action automatically connects the private alarm system with the city system; pulling the lever down with the door open sends an alarm to the fire station and repeats the local alarm.

The necessity of notifying patients when fire is discovered will depend largely upon the seriousness of the fire and the character of the patients. All fire gongs intended for use when the sounding of a general alarm

becomes necessary should be arranged so as to function only when set in motion by authorized parties, either from any one of the many boxes equipped for dual signaling or by means of a manually operated code signaling device located on the control panel. Where more than one building is involved the signals should be transmitted only to the building in which the fire has taken place, so as not to cause panic conditions in building not affected or in danger.

Open Circuit Systems Not Recommended

Open circuit fire alarm systems are not so satisfactory. They are unreliable and depend upon constant testing to insure their operation when required, and it is at such times that they are usually found to be inoperative owing to wires being broken, available current cut off, or batteries low or dead. Closed circuit systems are constantly under electrical supervision, maintained by a small amount of current derived from the battery constantly flowing over the circuits. An interruption to this current or the circuits over which it flows upsets the normal conditions and causes the operation of devices at the panel control board which in turn sounds the trouble alarm.

The operation of fire alarm equipment in hospitals and similar institutions from power derived directly off the lighting circuit is not the best engineering practice for the very particular reason that should an interruption occur in the lighting current the fire alarm system immediately becomes inoperative and useless. The use of open circuit fire alarm systems and systems operating directly from the lighting circuit is not approved for hospitals by underwriters. The N.F.P.A. permits of a current supply through the regular electric light system where it is acceptable to the local inspection department.

All such installations should be made in conduit to conform to the underwriters' rules and regulations. An improperly installed system is oftentimes worse than none and may even increase the fire hazard.

Set aside one day, Mr. Superintendent, to go over your building thoroughly from basement to roof, see to it that there is no accumulation of combustible material, check your exits, examine your extinguishers, ascertain if you can signal for the fire department other than by means of telephone; if you have not organized a safety corps, do so. If your institution is not equipped with a modern alarm system take it up with your board. You owe it to your patients. Let us hope that there will be less disastrous hospital fires in the future.

In speaking before the National Methodist Hospital and Home Association, Mr. Ralph Welles Keeler, director of publicity of the hospitals and homes of the Methodist Episcopal Church, said: "A great deal of leaflet and booklet publicity fails to be useful because its set-up is bad. Superintendents of hospitals or homes are not necessarily good judges of publicity or printing. Get a little advice. Study your own attitude toward printed matter that comes to you. Examine a type book. Remember that what you print you want read. As for half-tones or cuts, use only those photographs that tell a story. Oh, the miles of wooden pictures with which some are trying to illustrate the activities of institutions! Have your half-tones made a screen suitable for the paper on which they are to be printed. If possible use paper that will take an average screen, so that the half-tone can be used for more than one job. It may serve for the annual report, for a program, for the press, and for a leaflet."



THE ability to perceive what constitutes true excellence is most often seen in those whose powers of perception have been whetted by comprehensive training and broad experience. It requires a keen and capacious mind to make the fine distinctions that are always contributive to correct decisions.

The enduring preference of the better minds in medicine and dentistry for Colgate's Ribbon Dental Cream furnishes a wholesome admonition to those who still cling to the notion that one tooth paste is as good as another.

Colgate's Dental Powder holds a high position among those of the dental profession who prefer a dentifrice in powder form. As with Ribbon Dental Cream, it is based on the same fine precipitated chalk and pure soap.

A copy of "A Babe in the House" booklet and a generous supply of samples will be sent to registered nurses postpaid on request.

MEDICAL DEPT.
COLGATE & CO.
Established 1806
New York, N. Y.



*Cleans Teeth
the Right Way*



OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by HERBERT J. HALL, M.D., President, American Occupational Therapy Association,
Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS,
Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and
MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

DEFENDING MY COMMERCIALISM IN OCCUPATIONAL THERAPY

BY CHRISTINE NEWMAN, HEAD AIDE, HOWELL STATE SANATORIUM FOR TUBERCULOSIS, HOWELL, MICH.

IN STARTING our occupational therapy department at Howell State Sanatorium, we had but a very small fund to exist on, so it meant I had to keep a close eye on the commercial side if we were to exist at all.

In looking about I have often seen good and precious labor put on the wrong article; I mean by that, an article that is not appealing to the general public because of its design. The misplacement of labor is very often the cause of poverty. A number of poorly selected articles, no matter how well made, would cripple financially any occupational therapy department, and, again, a number of well selected articles would contain just as much therapy and sell with a profit that would make any department self-supporting.

When I first came here, some of our women patients who had been in a sick room for months and were nearly exhausted financially, were putting days of labor on a crocheted cap which they would sell to their next door neighbor for the precious sum of one dollar. Here is where an occupational therapy aide may step in and give both a therapeutic and financial aid. Give that same patient one of the pretty articles in vogue today, and in the same time she will double her dollar and will receive more therapeutic value of the novelty and satisfaction of the work.

Both Money and Therapy Aim

There can and should be both money and therapy in the right article.

The first thing I try to do is to find articles the public wants. If the public wants it, it usually is pretty. Pretty things, as a rule, bring harmony. Harmony brings relaxation and relaxation, we all know, is a great factor in bringing about a cure. A beautiful room, a beautiful piece of pottery or even a little scene will bring a spark of peace to any of us. I often hear my patients say, "Why I sleep so much better and my appetite has improved so since I am doing occupational therapy!"

In running our department here, a patient makes one thing for himself and one thing for us. If he wants to keep his own article he may do so; if he wants to dispose of it, I sell it for him. The articles made for the sanatorium, of course, have to be sold for the maintenance of the department.

When a patient is sent to me from the doctor, I gen-

erally know what condition he is in; so I show him a number of things he may do for himself, things within his strength and capacity. He usually chooses something he wants and I think I can safely say there is therapy in making something you want and like. On the other hand, there may be monotony in making a second article of the same kind, for your want is satisfied and your enthusiasm for that article is gone; so I let that patient make something for me that I have need of. There may be a number of articles, corresponding in labor and value to that of his own. We usually find something he is just as enthusiastic about. (Articles made of dyed milkweed, such as trays, muffin stands, tea wagons and serving tables for breakfast rooms have been successful in every way). For therapeutic purposes an article made of milkweed contains many operations. If the institution is located in or near the open country the exercise of gathering the milkweed will be attractive to the patient. My patients gathered so much last autumn that I still have a supply. Then the milkweed has to be carefully peeled and dyed in gasoline and tube paint the desired color, and, when dyed, put in a fine layer on the article; then follows the processes of weaving, staining and shel-lacing.

I do not say that everyone likes butterflies and milkweed, but it has a wonderful appeal to the majority of people, and our articles sell as fast as we can make them.

Our muffin stand, which costs us \$3.50 to make, sells fast at \$15. Still a merchant having to pay for the labor could not sell it for less.

Labor of Sick as Valuable as Well

I have heard occupational therapy people say, "We sell our articles ten above cost." But, tell me, why should not the labor of an ill man be just as valuable as a well man, providing it is well done?

There is despondency in receiving less for your labor because you are ill, and the psychological effect upon a patient who feels that his effort is worth less because of his illness is anything but healing.

Bernard Shaw tells us we can live three thousand years if we think so. Personally, my wrinkles are beginning to appear, so I beg heaven protect me from such a calamity. But nevertheless much wisdom is put into

Approved by Hospitals

EVERYWHERE hospitals are proclaiming their approval of the special packing of KNOX SPARKLING GELATINE in one and five-pound cartons.

Recognized by dietitians, physicians and food authorities as the standard of purity for over 30 years, this special packing of Knox Gelatine, in one and five-pound cartons, makes it additionally desirable for hospital use.

For nurses' class work we recommend Knox Gelatine, Plain Sparkling or Sparkling Acidulated, in our regular household packages, each of which make four pints of jelly.

Eminent authorities find great value in the use of KNOX SPARKLING GELATINE in milk for infants and adults because of a greater absorption of milk and for preventing digestive disorders from the non-emulsification of the fat masses.

KNOX

SPARKLING
GELATINE

is not alone used as a protein sparer but its value as an appetizing conveyor of nutritious foods and in the preparation of desserts and salads is pre-eminent.

Write for special hospital quotations on quantity purchases of the one and five pound cartons.

CHARLES B. KNOX GELATINE CO.

400 Knox Ave., Johnstown, N. Y.



the four famous words—"Thinking makes it so." So, first of all let's make our patients think "up" by having everything on the upward path around us. We can do so by putting much thought and care on our selection of articles.

In the world of merchandise, it is always the idea that sells, the inventor or designer being the "main spring." A manufacturing house with a clever designer, together with good management, is successful. A manufacturing house with a poor designer is not successful, because of valuable labor put on unsalable things.

An occupational therapy aide particularly needs clever things because she is too poor to put her valuable labor on things that will not sell. I know this sounds very commercial, but I still maintain there is just as much therapy in a number of salable things as in the same number of unsalable things, and I can do far more for my patients if my department is on paying basis.

Last week one of our patients had to go to the poorhouse. His condition was not such that he was able to support himself. Still since he had more than outstayed his time here, he had to make room for someone else. The last day he was working a little hard to finish a lamp. When I asked him what he was going to do with it, he turned and said, "Miss Newman, me no money. Fifty cents all. Me sell it." Fifty cents was all he had, and he was going to the poor house. A lamp is not easily sold in a day and I was afraid if he took it with him, not knowing how to go about it, he would sell it for less than its worth; so I spoke to Dr. Pierce about it and we found our department was able to buy it back from him. Thus the poor boy went away with, to him, a full purse.

In taking inventory, I find that our expenses the first ten months were \$1,197.30. That includes my salary, which the first year was very small. Cash received on articles sold for the sanatorium was \$818.35, that leaves \$378.95 which it cost the sanatorium to maintain the occupational therapy department the first year.

The second year I feel confident will entirely pay for itself, as the first year of any undertaking is spent more or less in experiment.

PSYCHIATRISTS EMPHASIZE WORK IN OCCUPATIONAL THERAPY

At the recent American Psychiatric Association meeting in Quebec, occupational therapy was a prominent feature. An unusually fine exhibit of craftwork from American and Canadian hospitals was shown at the Chateau Frontenac. Much credit is due to the head aides who prepared the exhibition and to Dr. Henry I. Klopp and Miss Clara H. Offutt who made the plans and collected the materials. Nearly every article shown carried a large tag, on which was given very briefly a history of the patient. In some instances, poorly constructed work, representing the original efforts of the patient, was shown accompanied by a piece of craftwork accomplished later after practice and training.

Not only was the exhibit appreciated by the members of the association, but large numbers of the townspeople of Quebec came to see what could be done by patients in hospitals for the insane. These persons got a new idea of hospital life, and it was evident that such exhibitions, when properly advertised, go a long way toward educating the public to the advantages and possibilities of occupational therapy.

The O. T. round table dinner was well attended, and the subsequent discussion lasted until almost midnight.

Dr. Horatio Pollock, state statistician of New York, read a significant paper in which he stated that there should be one occupational teacher for every 100 patients in state hospitals and that such an arrangement would actually represent a hospital economy rather than an additional expense because the occupied and interested patients would require far less ordinary attendance.

Dr. McKenzie of Kalamazoo, Mich., said that the occupational therapy aide was, at the present juncture, better qualified than the attending physician to decide what the individual patient's occupation should be and how long it should be continued. He felt that the greatest immediate need lies in the education of medical men in the possibilities and limitations of occupational therapeutics.

Dr. F. E. Lawler of the Nova Scotia Hospital in Halifax expressed the opinion that even the insane should receive money or some other material reward for their occupational therapy efforts. He spoke of one patient who had done good work and who, when asked what he would like to have as payment, said that nothing would please him better than a bottle of whisky. The coveted reward was forthcoming, and Dr. Lawler assured the meeting that no harm came from the allowance.

The next annual meeting of the Psychiatric Association is to be held at Detroit, Mich.

O. T. EXHIBIT DRAWS INTEREST OF DOCTORS

An occupational therapy exhibit at the City Hospital of St. Louis was featured during the meeting of the American Medical Association. The graduation exercises of the St. Louis School of Occupational Therapy also were held at the City Hospital at this time. Not only were the workshops and school rooms in the City Hospital open to the visiting doctors, but a comprehensive display of the work of the students of the St. Louis School was on exhibit.

Occupational therapists were gratified by the large numbers of visiting medical men who thronged the City Hospital and School Exhibition, the Junior League Workshop and the occupational therapy department at Barnes Hospital. It was regarded as an index of the growing interest of the medical profession in occupational therapy. Several doctors stated that the occupational therapy activities interested them more than any other feature of the meeting.

THE ROLL CALL Illinois

No new activities since the last report.

Manitoba

The annual meeting of the Manitoba Society of Occupational Therapy was held on June 1, when the following officers were elected for the coming year:

President, Miss E. A. Griffin; vice president, Mrs. J. P. Oliver; treasurer, Miss Jessie Stewart; secretary, Mrs. K. Stewart-Hay; board of management: Miss Hickie, Miss Buchanan, Miss Rice, Mrs. Wood, Mr. Wartens.

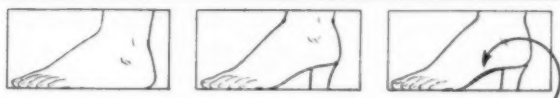
At a meeting of the board of management held on June 12 it was decided to hold a large public meeting in the autumn, with a view to securing new members and extensive publicity.

It was also decided to give an educational course and a tentative scheme was briefly outlined and an educational committee formed.

Maryland

The Maryland Society for the Promotion of Occupa-

How nurses keep their feet in shape— ready for any task



Nature plans that the foot rest on heel, ball and outside arch.

Civilization demands that heel and arch be raised.

The Arch Preserver Shoe satisfies both Nature and Civilization.



THEY give their feet the "barefooted" advantages of foot length support by wearing the Arch Preserver Shoe. They keep their feet free from strain—free from discomfort. Thousands of nurses have found foot vigor by wearing the Arch Preserver Shoe; they have made their feet a real help instead of a handicap.

The concealed, built-in arch bridge of the Arch Preserver Shoe makes these "barefooted" advantages possible, without interfering with style. The Arch Preserver Shoe offers the smartest styles for professional and social wear.

Write for booklet 83, "Why the Arch Preserver Shoe Preserves the Foot."

We will send name of dealer or you may call the "Tel-U-Where" Bureau in your city.

THE SELBY SHOE COMPANY

73 Gallia Street

Portsmouth, Ohio



ARCH PRESERVER SHOE

tional Therapy met Monday, June 19, at the home of Dr. W. R. Dunton. The questions of registration, national uniform, pins or insignia, representation on the national society, and joint dues of the national and local society were discussed.

The meetings of the Maryland Society are discontinued during the summer months, but it is expected that the first meeting will be held in October as a joint meeting with the Maryland Medical Society.

Massachusetts

The Massachusetts Association for Occupational Therapy is continuing its policy of publicity meetings so that knowledge of occupational therapy may be furthered throughout the state.

A meeting was held at the home of Mrs. Henry G. Lord, Brookline, May 23 at which Dr. Joel E. Goldthwait spoke on "Occupational Therapy, What It Is and What It Does," and Dr. John D. Adams on "Occupational Therapy in Civilian Hospitals." This program was repeated at the Community House, Dedham, June 1.

Miss Robeson spoke on occupational therapy at the Bulfinch Street Church, Boston, recently, showing lantern slides; the lecture resulted in a generous contribution to the work from the Lend-a-Hand Society of the church.

Dr. Adams addressed the medical staff, nurses and trustees of the Burbank Hospital, Fitchburg, on June 8. A request for an aide and assistance in organizing an O. T. department resulted.

On June 15 Dr. Adams spoke at the nurses' graduation exercises of the Bishop Memorial Training School at Pittsfield.

The Bureau of Occupational Therapy, now conducted by the Massachusetts Association, has moved into its new quarters at 443 Boylston Street, Boston. It is a corner shop on a busy shopping street and a great increase in public interest and sale of product is already evident. Consignments of finished occupational therapy output are coming from hospitals in Jamaica, Pennsylvania, Connecticut, New York, as well as from Massachusetts, and the Bureau has been recently in touch with aides and people desiring information in thirty-six different states. It is the desire of the association to make the Bureau a real and useful factor in the occupational therapy field throughout the country. The Bureau will buy materials and sell the finished product for any hospital.

Michigan

A meeting of the Michigan Association of Occupational Therapy was held at Newberry House on the second Tuesday in June. A picnic was given at Belle Isle for the Michigan association members and patrons on the last Tuesday in June. No business meetings of the Michigan

Association of Occupational Therapy were held during the months of July and August.

Missouri

On May 10 the active members of the St. Louis Occupational Therapy Society abandoned their organization and became members of the Missouri Association for Occupational Therapy with an understanding that the occupational therapists by autumn would begin holding their monthly meetings for the mutual help and interest of the work. Dues were made one dollar per year. Thirty-one occupational therapists were admitted to the organization as active members.

The St. Louis School of Occupational Therapy (one of the activities of the Missouri Association) completed the lecture and craft course for its sixth class, May 22. Exercises were held in the St. Louis City Hospital where Dr. Harry E. Mock of Chicago and Mrs. Carl Henry Davis of Milwaukee gave illustrated talks.

Owing to ill health, Miss Alice H. Dean, head instructor of the school, and Miss Martha E. Gilbert, head instructor of the Shop for Handicapped, had to abandon their work with the organization in May.

Miss Idelle Kidder, director of the association, resigned her position in July for an indefinite rest after having directed its various activities for three years.

New York

Several thousand dollars were cleared at the recent Motor Truck Circus for the benefit of the New York State Association. Fred Stone thought of it in a hurry when the Occupation Therapy Society told him that it needed help to enlarge its work of rehabilitating ill and injured work-

ing men and working women. He sketched out the program of his Monster Motor Hippodrome and Wild West Show, and got the Lambs' Club, Tex Rickard, Keith's, National Vaudeville Association and others to promise to support him. Out of the impossibility of building a stage on the green in front of the fair grounds grandstand was born the motor truck plan—twelve trucks, each with a theater stage mounted upon it, to move in rotation before the audience, pausing at intervals to give its performance. No stage hands needed; no changing of scenery; just change the stage.

Twenty-two new members have been added to the New York Society.

A summer school of advanced classes has been conducted at Byrdcliff under the direction of Miss Zulma Steele and Miss Bodka Thompson.

Ontario

A publicity campaign was launched in June with various articles appearing in local publications. The funds for this campaign were raised at a garden party.

The annual convention of the American Occupational Therapy Association at Atlantic City, September 25-28, marks a milestone in the growth of the association. It is the first convention in connection with the American Hospital Association and is in a sense a formal recognition of occupational therapy as a definite hospital department. This joint convention gives many advantages to occupational therapists, among them reduced railroad rates.

The American Hospital Association is able to offer us meeting rooms and exhibition space without any charge, but perhaps the best of the whole matter is the prestige which comes to our Society through this union of interests, says Dr. Herbert J. Hall. Occupational therapy is definitely a hospital function, and though our own meetings will be for the most part separate this arrangement will give us opportunity, as never before, to put our work rationally and logically before the hospital world. This Atlantic City convention should prove to be the best and largest in our history.

The complete program is printed in the supplement to this issue.

A Floor of Captive Sunlight

What could you find more appropriate for a sick room than a flooring which holds in itself the airy, golden spirit of sunlight?

Maple, varnished, gives you such a color. Its quiet cheerfulness finds response in the mind of the patient, and helps create the mood most favorable to recovery.

But beauty is only one qualification of Maple for hospital floors. It has unusual cleanliness, even when used bare and untreated in wards and hallways. The wood is so tight-grained and smooth surfaced that it has remarkably low absorbency and is easily cleaned. Its tough-fibred texture prevents slivering. Maple polishes under friction; this is the wood which outwears stone.

For Color— BEECH AND BIRCH

Add the ruddy tinge of sunset to Maple's sunlit color, and you have the warmer tone of Beech and Birch. In wear these two woods are closest akin to Maple.

This trio of floorings offer you a range of service and color possibilities which meet the needs of hospital use, in private rooms, wards and halls, in office or kitchen—wherever wear and cleanliness is essential or beauty desired. Maple, Beech and Birch floorings—all three—are manu-



The quiet cheerfulness of a Maple floor finds response in the mind of the patient.

factured from the slow-growth, climate-hardened timber of Michigan and Wisconsin, and guaranteed in grade and quality by the trademark MFMA.

"Color Harmony in Floors"

—is the title of a book, just published, which will open interesting decorative possibilities to you. Ask your lumber dealer for a copy, or let us send you one with our compliments. For full technical information, and verification of Maple's wearing qualities, we refer you to your architect.

MAPLE FLOORING MANUFACTURERS ASSOCIATION
1065 Stock Exchange Building, Chicago

MFMA The letters **MFMA** on Maple, Beech or Birch flooring signify that the flooring is standardized and guaranteed by the Maple Flooring Manufacturers Association, whose members must attain and maintain the highest standards of manufacture, and adhere to manufacturing and grading rules which economically conserve every particle of these remarkable woods. This trademark is for your protection. Look for it on the flooring you use.

Floor with Maple Beech or Birch

When using advertisements see Classified Index, also refer to YEAR BOOK.

Pennsylvania

The commencement exercises of the Philadelphia School of Occupational Therapy were held at the School, 2200 De Lancey Place, on June 8. The Rev. Dr. Jeffreys, rector of St. Peter's Church, made the opening prayer.

The dean, Miss Florence W. Fulton, spoke a few words in explanation of the work of the school, the type of student needed and the mission of the aide in the service.

Mrs. James Starr, Jr., president of the board of directors, presented the diplomas.

The Hon. Roland S. Morris, formerly U. S. minister to Japan, gave a stirring address in which he congratulated the school and the students upon being pioneers in this branch of the medical service. There were thirty graduates and of this number thirteen have already been well placed, positions have been offered to others, and it is hoped and expected that all will be placed before the autumn. The school has been very successful so far in placing all its graduates who desire positions.

Since the last report occupational therapy has been started at the Harrisburg State Hospital, Harrisburg, Pa.

At the request of Mrs. Slagle, the Philadelphia School of Occupational Therapy sent a small but comprehensive exhibition to Chautauqua under the direction of one of our graduate aides, Mrs. Barkley Johnson.

Washington, D. C.

No report.

Wisconsin

Miss Julia Hooker, a graduate of the Milwaukee-Downer College Training School, has accepted a position with the Junior League of Milwaukee. She will prepare designs for occupational therapists in the city and state and will be in charge of the paint shop and sales room.

Miss Grace Clapp, Ph.D., has been appointed director of the training school at Milwaukee-Downer College. Plans are being completed for the autumn classes.

REHABILITATION IN MASSACHUSETTS

THE federal government is holding out a helping hand to the states in developing another phase of conservation—human engineering.

Those who are physically disabled as the result of industrial or other accident or disease are no longer to be merely extended sympathy and to be forced to drift to the dead-ends in industrial and social life. Instead constructive efforts are to be made to assist them to utilize their remaining powers in the best possible way for their own independence, advancement and happiness, and the economic betterment of the community.

In a leaflet entitled "Vocational Rehabilitation for Persons Disabled in Industry or Otherwise," the Massachusetts department of education outlines the type of service which may be rendered. The leaflet reads:

"By an act of the Legislature approved by the governor May 25, and effective August 25, 1921, the commonwealth of Massachusetts accepted the provisions of an act of Congress whereby 'persons disabled in industry or otherwise,' and residing in the commonwealth of Massachusetts may be enrolled in vocational training courses planned for their vocational rehabilitation. For this purpose the commissioner and advisory board of education are constituted and designated as the state board for vocational education and directed to cooperate with the Federal Board for Vocational Education, and to establish and maintain, or to assist in establishing and maintaining, such courses as it may deem advisable and necessary.

"At this time it is held that the following persons are not eligible for this training:—

"Aged or helpless persons requiring permanent custodial care.

"Any inmate of a state institution, or any person confined in a correctional or penal institution.

"Any person deemed not susceptible of rehabilitation.

"Persons under the age of fourteen, and in some instances sixteen, years; or persons desiring courses in general education.

"Enrollment in and supervision of these courses will come directly under the rehabilitation section of the division of vocational education in the department of education.

"Upon application to the rehabilitation section persons disabled in industry or otherwise may receive any part or all of the following types of service:—

Counsel upon training for placement in the former occupation or a new one.

An opportunity to enter upon a suitable course of training: in trade, technical, agricultural, or commercial schools; by correspondence courses; or by placement in industrial or commercial establishments.

Supervision and guidance during training so that the greatest benefit may be derived therefrom.

Help in securing placement when the course of training has been successfully completed.

Advice and assistance in securing artificial limbs and other orthopedic and prosthetic appliances at minimum cost and inconvenience.

"Persons eligible for vocational rehabilitation under the provisions of this act should apply to the rehabilitation section as soon as possible after suffering the disability which incapacitates them for employment. They may apply in person, or the application may be made for them by an employer, an insurance company, a hospital, a physician, a social worker, a relative or friend, or by an interested citizen or agency. As far as possible persons interested in obtaining vocational rehabilitation but unable to come to the office will be visited at the hospitals or in their homes by an agent of the rehabilitation section.

"Under a plan approved by the governor of the commonwealth, the Massachusetts Department of Industrial Accidents is cooperating with the Department of Education in the administration of the above act. By this plan of cooperation persons injured in industrial accidents and eligible for vocational training are referred to the rehabilitation section.

"The cooperation and assistance of hospitals, medical associations, chambers of commerce, employers' associations, labor unions, social agencies, fraternal organizations, and other organizations of a like character are earnestly solicited.

"Applications received from any source will be considered individually and plans will be arranged which seem best suited to bring about the rehabilitation of the particular person.

"For further information concerning rehabilitation under the provisions of this act, persons interested may address or call upon Herbert A. Dallas, Supervisor of Rehabilitation, Division of Vocational Education, Room 212, State House, Boston 9, Mass."

Under the existing arrangement, the initiative remains with the several states. The federal government however through its Board for Vocational Education encourages action by matching dollar for dollar the expenditures for rehabilitation made by the cooperating state.

They Tested Their CASTLE for accuracy

(The Hospital Superintendent and Surgeon were talking—Series III)

"Good morning Doctor"—

"Morning. You know that new Castle Sterilizer—I like it. I was here yesterday when Miss Smith ran it. Apparently it's as good as they said it was. It will melt Diack controls anywhere in the dressings."

"Right, we couldn't do that with the old one. I wonder if we were sterilizing at all."

"That's the question, but we certainly will now. The U. S. Bureau of Standards says that these controls don't melt until after exposure at 250° F.

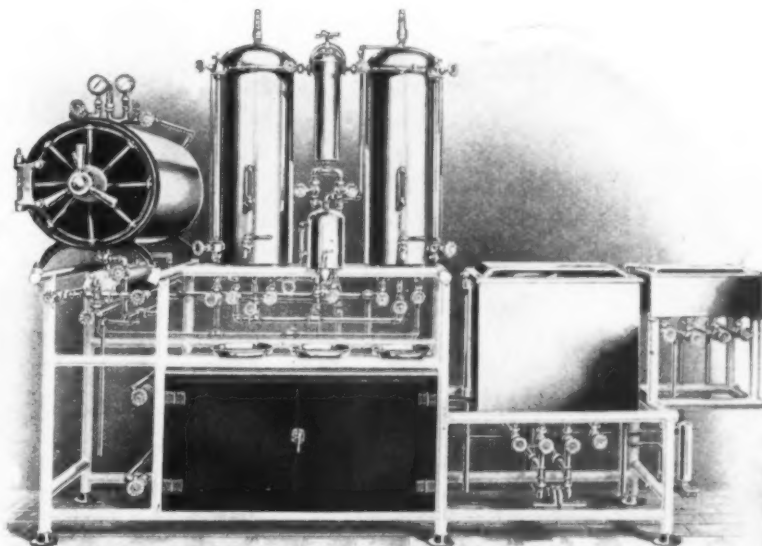
"Yes each of the six tests Miss Smith made was 100% positive. But Doctor, she's worried because there is no vacuum feature."

"Certainly *not*, that's the beauty of the thing. It's better to drive *all* the air out by steam pressure than to get a *fraction* of it out by vacuum. You know it is the presence of the air pockets that prevents sterilization. And the dressings come out dry, too. The steam jacket does that. I'm much pleased."

Write for Castle sterilizer specifications



*Makers of the largest line of
Sterilizers for Hospitals,
Laboratories, Physicians
and Dentists*



WILMOT CASTLE COMPANY, 1151 UNIVERSITY AVE., ROCHESTER, N. Y.

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary Committee on Dispensary Development, United Hospital Fund of New York, and Chief, Service Bureau on Dispensaries and Community Relations or Hospitals, American Hospital Association, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association, 370 Seventh Avenue, New York

VENEREAL DISEASE CLINICS IN THE CITY OF NEW YORK

MRS. Lesley Funkhouser's study of the venereal disease problem in the city of New York, a discussion of which appears in a recent issue of the *Journal of Social Hygiene*, discloses much interesting and valuable information in regard to venereal disease clinics.

The study was undertaken by the sub-committee on venereal disease of the Charity Organization Society, under the direction of Mrs. Funkhouser. It was approached from three angles: that of the venereal disease patients themselves as they appear under the care of the society; the facilities available for examination and treatment; and the existing legislation affecting the situation.

Clinics Are on Increase

The study of facilities for the examination and treatment of venereal diseases in the city shows an increase in the number of venereal disease clinics since 1919. The survey indicates that there are about fifty-five clinics and six hospitals available. Of these, thirteen clinics and two hospitals were selected for intensive study. They represent the best existing facilities at present for the examination and treatment of patients from the medical standpoint of the American Social Hygiene Association and the social standpoint of the Charity Organization Society. The data were obtained through interviews with the medical director of the American Social Hygiene Association and the executive officers and case workers of several social agencies; through the reading of case records of the society; and through visits to the clinics themselves and interviews with the head physician and social worker of each clinic. The study was confined almost entirely to that of the syphilis department of each clinic.

The following rules seem to be common to all of them:

1. Clinics are not restricted. Patients from any part of the city will be accepted without question.
2. No charge is made to patients who are unable to pay for treatment.
3. Wassermann tests are given direct, if so requested, without the necessity of having the patient pass first through the general medical clinic.
4. Wassermann tests are not taken as a routine part of the general medical examination.
5. Diagnoses can only be obtained by letter from the superintendent of the hospital, and as such, are considered strictly confidential.
6. Treatment is given in courses, and no patient is considered discharged for a period of at least two years.

The physicians estimate that an average of from 30 to 50 per cent of their cases discontinue treatment before being cured. But few of the clinics use the complement-fixation test for gonorrhea or the provocative Wassermann test for syphilis. All of the clinics claim to make daily reports of their infectious cases to the Department of Health, but the Department of Health is not used to secure compulsory treatment for such cases.

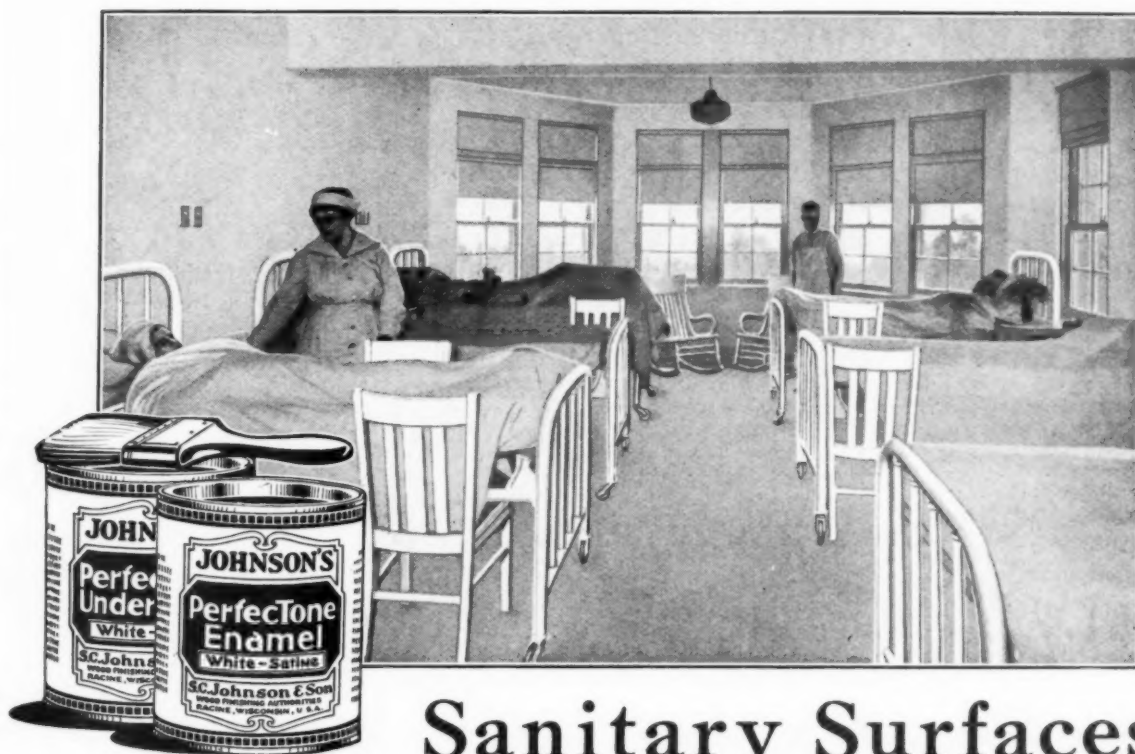
Weak Points in Clinics

The clinics investigated are located in all sections of the city. They are handling from 30 to 4,000 active cases each, according to the size of the clinic. Although steadily improving, they show the following weaknesses at the present time:

Lack of clinic space.—Six of the clinics have no provision for the separation of men and women. Four have separate rooms for each, and three provide for treatment of each sex on separate days. At best, the syphilis department of the clinic has at its disposal only two or three rooms and these rooms have to be used for both Wassermann tests and mercury and salvarsan treatments. Rarely are there separate rooms for examination and for treatment. There is also a deficiency of tables for salvarsan administration, most of the clinics having only one or two tables, which results in much congestion and discomfort.

Lack of clinic personnel.—Most of the clinics have only one or two doctors, and in many cases the same physicians are obliged to carry the work of the skin clinic in addition to that of the syphilis clinic. Two of the clinics have no social worker and only two have more than one. In most of the clinics the social worker's time is so taken up with clerical and routine procedures that very little can be done in effective follow-up work. It is easily seen that in a venereal disease clinic, individual attention and follow-up care are essential, and that clinics carrying from 500 to 1,000 patients cannot carry on this work with only one social worker. There is also a need for more trained laboratory technicians. Few of the clinics have such technicians as full-time workers, and this deficiency causes much delay in securing results of tests.

Lack of adequate hospital facilities.—This lack is especially felt in regard to the making of spinal punctures. All of the clinics depend upon beds in the general hospital wards for the purpose of spinal treatments, yet only four made any special provisions for accommodations of this



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sort. There is also no provision, except in two of the large municipal hospitals, for the admission of patients to the hospitals for observation or for specialized treatment.

Clinic fees too high.—The charge for salvarsan treatment was found to range from \$1.25 to \$3 a dose. The charge for spinal puncture ranges from \$2 to \$4. These are almost prohibitive to the majority of patients whom the clinic handles.

Lack of free night clinics.—The study revealed only nine night clinics in the city, and of these, only the Department of Health clinic gives free treatment. Four others occasionally give free treatment to indigent patients. None of the night clinics make Wassermann tests. Thus it is impossible for a working man to secure these tests unless he can be excused from his work during the day.

Inefficient record system.—Few of the clinics use a special form for their venereal disease cases. Thus there is no detailed information about the social history of the pa-

tient and this phase is overlooked. Also, because of a confused filing system and lack of experienced clerical workers, records are sometimes lost or misplaced, so that social workers cannot secure data which would be important in their work.

Only two of the large municipal hospitals make provision for bed cases of venereal disease. These have fairly adequate accommodations for both gonorrheal and syphilitic patients, but they will not keep chronic third-stage cases of the latter more than a year.

In spite of the various deficiencies observed during this study, Mrs. Funkhouser notes an encouraging advance in results accomplished, even in the two-year period during which the study was made. Social workers are undoubtedly improving in knowledge of the medical and social factors involved. The growth in the number of venereal disease clinics and in their service to patients is something which should act as an incentive to continue work on this problem so that the situation may be entirely alleviated.

BUFFALO CLINIC IS ESSENTIAL TO COMMUNITY HEALTH, SURVEY SHOWS*

THE facts brought out by the social investigation of the Buffalo Urologic Clinic, which was made by the Buffalo Foundation at the request of the board of managers of the department of hospitals and dispensaries, indicate that the maintenance of a clinic for the diagnosis and treatment of venereal diseases is absolutely essential to preserve the public health of the community.

The venereal disease clinic of Buffalo occupies a series of rooms in the Health Center Dispensary Building at 51 Court Street. The personnel consists of a part-time physician-in-charge, five part-time assisting physicians, a head nurse and an assistant, an orderly and a clerk. The quarters are thoroughly sanitary.

Class of Patients Treated

During the period of thirty days in which the social investigation was being made, there were admitted to the clinic 165 new patients, 133 white and 32 colored. Of the 165, only 27 were females, but indications are that with further separation of the sexes the attendance of women will be markedly increased.

The ages ranged from 9 to 79 years. Children under 16 are sent to the children's clinic for regular treatment. The marital conditions of the patients is as follows: Of the 138 males, 34 were married; of the 27 females, 19 were married.

Of the 165, 108 were located either at or from their homes. The number of unlocated persons after one interview represented 19 per cent of the total. Most of these had deliberately given fictitious addresses in order to cover up their tracks. A regular social worker employed permanently in the clinic could trace these patients by asking to have them sent back to the interviewer in their next visit to the clinic.

As regards employment, only 42 of the 165 were known to be employed. Four were students, and for four others no information was available. Of the 115 who were not employed, 14 had been unemployed less than three months,

54 from three to six months, 15 from six months to a year, and six had been unemployed for longer periods, up to six years; 27 failed to give length of unemployment. The majority had been engaged in common laboring jobs, in factories, railroads, steel mills, etc.

The occupations can be classified into 37 different groups. The two largest are common laborers and factory workers. Some of the others were sailors, chauffeurs, garage workers, steel workers, domestic servants, motormen and even a clergyman.

Of the 42 who were employed, six were earning less than \$10 a week, 17 were earning from \$10 to \$19 per week. Of the latter, five have from four to six dependents. Twelve patients earn between \$20 and \$29. Only five patients earn from \$30 to \$40. Most of the patients earning from \$20 to \$40 have dependents, which makes clinic treatment the only kind that they can have available within their budgets.

Conclusion of Sub-Committee

As a result of the investigation the Buffalo Foundation comes to the following conclusions:

The clinic managed under the municipality becomes a very important part of the educational program being carried on for the cure and prevention of venereal disease. Buffalo should enlarge the local program very much. There is need for much education through lantern slides, lectures, and films, by qualified persons. Industrial concerns should cooperate strongly in this.

The Buffalo department of hospitals and dispensaries deserves much credit for having entered this field early on the curative side and for having done a very creditable piece of work. Other agencies ought to do their share to develop the preventive and educational activities.

Much education is needed to instill into the minds of the public the knowledge that venereal disease must be treated as an infectious disease and cured as completely as possible, and that such conditions will never be attained until the public accepts the conditions as they are and agrees to do away with the traditional wall of mystery which has been established about the whole matter.

*Buffalo Foundation's Survey of the Urologic Clinic, Health Center Dispensary No. 5. From the report of Frances M. Hollingshead, M.D., director of Buffalo Foundation. Abstract Service, American Social Hygiene Association, February 15, 1922.

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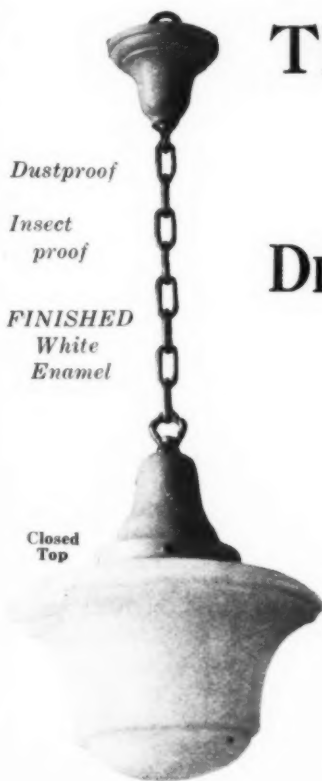
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HINTS TO HOSPITAL SUPERINTENDENTS

OUTDOOR TREATMENT ON THE HOSPITAL ROOF

Are you treating your patients fairly in the matter of outdoors and sunshine? There are many diseases benefited by outdoor treatment and these possibilities are being further recognized every day. The foresighted superintendent will keep a step ahead of the times, and not allow his institution to be left behind in the onward march of medical procedure. By the full use of the hospital roof every institution may afford outdoor treatment, perhaps in a more efficient manner than if extensive lawns and gardens were provided. On the roof the patients may be sufficiently protected from the weather when necessary, and may be kept under closer supervision by the nurse in charge. You may say that your institution is so located that the roof would be smoky and disagreeable. Then you should work for a lessening of the smoke horror or a different location for the institution.

WASHING SOILED DRESSINGS

The following formula is used with success in the laundry of the Presbyterian Hospital of Chicago for the washing of soiled dressings:

- Four cold rinses of two minutes each,
- Three soda baths of ten minutes each,
- Three hot rinses of two minutes each,
- Bleach ten minutes and bring up to boiling point.
- Three hot rinses and two cold of two minutes each.

After the dressings are received in the supply room from the laundry, they are separated, folded, wrapped and sterilized for three consecutive days.

THE TREATMENT OF RUBBER GLOVES

Nurses at the Royal Victoria Hospital at Montreal, Quebec, are given the following instructions in the notes of their supervisor, Miss B. K. Felter, O.R., for the care of rubber gloves:

"After rubber gloves have been used they are to be washed on both sides with cold running water, boiled in 1 per cent solution of sodium carbonate for five to twenty minutes. Then they must be dried, powdered on both sides, patched if necessary, mated properly, placed in a cotton cover and sterilized for twenty minutes at ten pounds of pressure."

TO MAKE SOFT SOAP

Many institutions find it economical to manufacture soft soap since it enables them to use up old grease and fat trimmings which would otherwise be pure waste. The following recipe for making soft soap is taken from the *Medico-Military Review*.

Old grease and fat trimmings, 12 pounds after ren-

dering; concentrated lye, 4 cans. Water sufficient to make 50 gallons of soap. Dissolve the lye in 6 gallons of water; add the grease and allow the emulsion to stand for two hours; boil for 30 minutes with constant stirring. During the boiling, small quantities of water, about a quart, must be added from time to time to prevent the mixture from boiling over the top of the can. After boiling for 30 minutes, sufficient water is added to make up the 50 gallons of soap.

MARKING RUBBER GLOVES AGAIN

The method of marking surgeons' rubber gloves in use at Brandon General Hospital, Brandon, Manitoba, has proved most satisfactory, the superintendent, Miss S. Persis Johnson, declares. The initials of the surgeon are marked on the cuff of the gloves with a caustic pencil and they remain there without detriment to the gloves.

DRESSINGS FOR ONE OPERATION

Sterile dressings and supplies which the Royal Victoria Hospital at Montreal, Quebec requires for one operation include the following:

- 1 doz. towels.
- 3 doz. flat sponges with strings.
- 2 bags—small sponges.
- 3 dressings and bandages.
- 1 gown and pair of gloves for each surgeon and nurse; also caps and masks. Ether cones for face cases.
- Roll dressing for arm or leg.
- 2 non-absorbent or kidney pads.
- ½ doz. abdominal towels.

THE FLY AND THE GARBAGE PAIL

Flies are perverse creatures. You may provide many traps for them and bait them temptingly, and a few will accept the invitation, but most of them will go to the garbage pail. If the trap is placed on the cover of the garbage pail every fly will be caught before he can make his escape.

LETTERS OF CLINICAL VALUE

Some hospitals make a practice in filing their correspondence to place all letters of clinical value to patients with the history. For example, letters from the patient's own physician, giving a knowledge of the case or letters bearing on the financial status of the patient are attached to his history and filed there.

"Cleanliness is the only real disinfectant. No epidemic can resist thorough cleanliness and fresh air."—Florence Nightingale.

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The Greeks and Romans missed a good thing. They did not know about coffee.

In Constantinople in the 16th century, coffee was so popular that refusal to supply a wife with a specified quantity per day was a valid cause for divorce.

The first café (coffee house) was opened in Paris about 1675.

Early coffee houses in London were regarded with suspicion as gathering places for vicious and criminal characters.

Coffee grows in all tropical countries. Four-fifths of the coffee used in the United States comes from South America.

The coffee tree is the aristocrat of the tree family and must be handled very carefully. Each tree produces about five pounds per year.

Coffee planting in Brazil was begun about 1725, but cultivation on a large scale dates from about 1867. Brazil now produces seventy percent of the world's supply.

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In 1829 the U. S. import of coffee was less than 100,000 pounds; in 1921 it was about 25,500,000 pounds.

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LETTERS TO THE EDITOR

THE QUESTION OF PEDIATRIC NURSES

To the Editor of THE MODERN HOSPITAL:

The need of pediatric nurses is becoming a more serious problem every day. The medical world has at last been awakened to the fact that our next generation depends upon the proper care and teaching of the present.

Institutions can render no greater service to a community than to prevent diseases, and keep babies well; herein lies the solution of infant mortality. The greater mass of the public, the educated as well as the uneducated, fail to fully understand the value of health, their responsibility in attaining it, and their right to demand it. There is, in short, a very decided lack of interest in human health.

We rightly and willingly pay heavy taxes and expend vast sums for the education of our children, and yet what is education without health? There are thousands of children every year failing to develop intellectually because they are physically unfit.

We do find some very enlightened health officers, nurses, and doctors who are seeking to install better methods or procedures. But, as usual, they are met with the cry, "It costs too much." Notwithstanding, a great reduction has been made in the infant death rate. But the question before us is, "Are our institutions going to awaken to the fact that the infant mortality cannot be kept down if they do not produce the nursing staff to help the community?"

Our large and small training schools of today all have the most marvelous surgery and adult medical staffs and equipment. But go further, and nearly always we find the children's department drifting along as best it can. The trained nurse of today, on an average, knows no more of pediatrics on receiving her diploma than the average intelligent mother who has had the care of her children. Why? Simply because the training schools have neglected to give her the proper training in that course.

Most of our institutions of today have enough pediatrics to get the nurse over an examination of ten questions by the state examiners. Do you think that this is sufficient to qualify a trained nurse to care for sick children?

The hospital I am connected with trains infant nurses only, these nurses are given a thorough training in infant care, including surgery and infant feeding. But we would not recommend our nurses as qualified to meet all the demands of the profession.

The shortage of nurses for infant welfare work is becoming a serious matter, but as long as our training schools for nurses do not demand a higher standard in their pediatric departments we cannot expect to fill the gap. As a general rule we do hear the nurses expressing themselves as not liking to care for children, but I think

this can be overcome by giving them a course in children's work in the same way that we do in surgery. They don't like pediatrics simply because they haven't had the proper training in that line.

If health protection is to be secured, the public conscience must be awakened to its importance, and the proper people must be trained to train others. We need faith in our cause and perfect organization to win in this fight, and if we have these fundamental qualifications the fight can be won.—Pediatric Nurse.

STEADY GROWTH IN A. H. A. MEMBERSHIP

The growth in the personal membership of the American Hospital Association can be readily traced from the following table published in a recent bulletin of the association. The two sharp drops in the total published roll were caused by the routine suspension of all members in arrears for dues. Many of these were later reinstated.

GROWTH OF MEMBERSHIP IN THE AMERICAN HOSPITAL ASSOCIATION.

Year—	Registered at Conference			Published Membership Roll							
	Personal Members.	Voting Inst. Delegates.	Total.	Personal				Institutional			
				Active.	Associate.	Life.	Hon.	Total.	Active.	Associate.	Total.
1899	9	9	9	..	..	..	..	..	..	..	..
1900	23	23	23	..	..	..	..	..	..	..	..
1901	44	44	44	..	..	..	..	..	..	..	..
1902	(?)	(*)	100	..	..	..	..	..	..	..	..
1903	45	45	45	..	..	..	..	..	..	..	..
1904	61	61	137	..	..	..	9	146	..	..	..
1905	77	77	201	..	..	..	10	211	..	..	..
1906	86	86	224	..	..	..	10	234	..	..	..
1907	132	132	273	..	..	..	13	286	..	..	..
1908	174	174	533	24	..	..	14	571	..	..	..
1909	204	204	531	51	..	..	14	596	..	..	..
1910	126	126	645	54	..	..	15	714	..	..	..
1911	286	286	788	40	..	..	15	843	..	..	..
1912	267	267	913	18	..	..	15	946	..	..	..
1913	376	376	996	20	..	..	15	1,031	..	..	..
1914	(?)	..	..	..	..	..	15	1,148	..	..	..
1915	(?)	..	..	..	..	..	15	918	..	..	..
1916	(?)	..	..	..	..	..	15	1,268	..	..	..
1917	(?)	..	..	..	..	..	15	1,241	..	..	..
1918	(?)	(*)	483	..	..	11	15	1,355	98	..	98
1919	216	190	406	..	..	11	15	1,060	285	..	285
1920	271	155	426	..	..	29	11	1,228	330	..	330
1921	328	156	484	..	..	31	11	1,386	409	..	409
1922	..	..	..	..	..	..	..	..	..	..	..

These Figures Will Be What You Make Them.

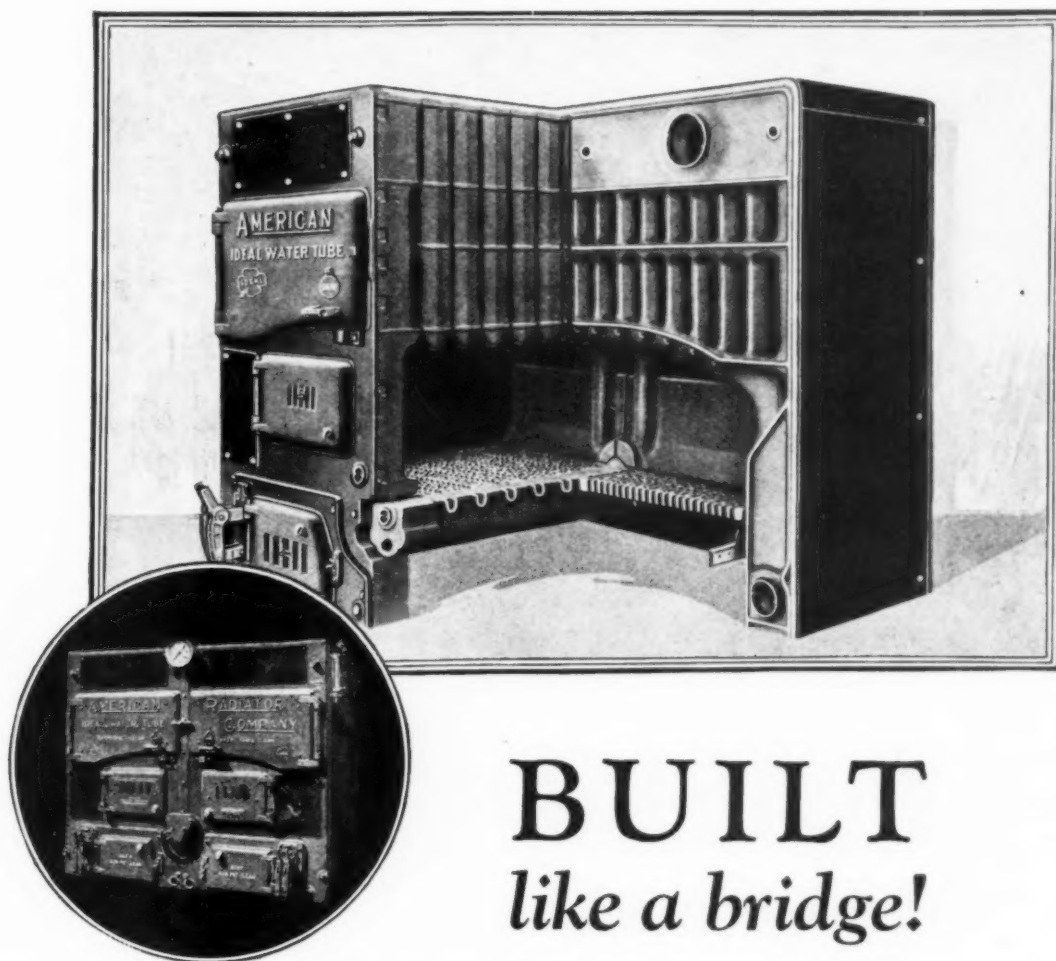
Actual Membership,

July 24, 1922.....1,208 | 241 | 32 | 10 | 1,491 | 458 | 6 | 464

*With guests.

Ah, when shall all men's good
Be each man's rule, and universal peace
Lie like a shaft of light across the land,
And like a lane of beams athwart the sea,
Through all the circle of the golden year?"

Germs, says the U. S. Public Health Service, are usually a hand to mouth affair. Better wash up.



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THE UNUSUAL DESIGN of the IDEAL 79-inch Water Tube Boiler is well shown in the cut-away view above.

Notice the bridge-like construction of the sections. No separate base is required; the weight of each section is self-supported by a substantial girder-like water-leg extending to the floor, which absorbs a large portion of the radiant heat below the grate and forms an air-tight, water cooled ash-pit.

The boiler is assembled in two separate halves, connected in the rear by single flow and return headers. Each half section has a cast-iron conical nipple connec-

tion at the top and bottom.

This unusual construction allows absolute free expansion and contraction, not only within each section, but of the entire boiler. All danger of strain at high firing periods is completely eliminated.

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BOOK REVIEWS AND CURRENT HOSPITAL LITERATURE

A MANUAL OF OBSTETRICAL NURSING

Prepared for Use in Connection with Textbooks of Obstetrics. By Nancy E. Cadmus, R. N., General Director of the Maternity Center Association; Graduate of the Presbyterian Hospital School of Nursing of the City of New York; former Superintendent of the Manhattan Maternity and Dispensary; former Member of the New York State Board of Nurse Examiners; former President of the New York State League of Nursing Education.¹

It is quite generally recognized that one of the most difficult problems in connection with the education of student nurses is to secure adequate instruction in obstetrical nursing, particularly if the parent school must send students to special maternity hospitals to get it. Equally difficult is the problem of managing a maternity hospital that depends on a constantly changing group of student nurses for the care of the patients and at the same time tries to give students a fair return in education for the work they do. In many obstetrical hospitals there is a change of students every two weeks. This does not mean that the entire group changes, but a certain number do. The result is that at any given time the students assembled for a given class may range all the way from the so-called "seniors" about ready to terminate their service, to the "juniors" who have just arrived. Added to this, any given class includes students who have come from a number of different hospitals, which invariably means differences in background and preparation.

From the teaching standpoint this represents an unusually difficult problem, and one that is so seldom met in any adequate fashion that where it is, it is considered an outstanding achievement, the fame of which is likely to spread abroad. It is an open secret that Nancy E. Cadmus, former superintendent of the Manhattan Maternity Hospital, was unusually successful in meeting this problem. So much so that for a period of years her work afforded an interesting demonstration of the fact that it was possible to meet the educational needs of the students, to provide adequate care for the patients, and to satisfy the claims of the hospitals sending students. It really was an unusual example of the possibility of satisfying what often seem to be antagonistic claims, and the mutual satisfaction engendered was no small part of the total result.

It is significant that Miss Cadmus has been willing to share the results of her efforts and experience with others. This Manual outlines the classes and demonstrations that are absolutely essential, stresses the correlation of theory and practice, even outlines quizzes. It is not intended to take the place of a textbook on obstetrical nursing, but rather to supplement such a text, and be used in connection with it.

It is peculiarly valuable for the instructor as well as the student, both of whom are often bewildered because the textbooks contain so much, and the time devoted to instruction is so limited. With this Manual as a guide, the essential subject matter can be encompassed in even a limited number of lessons.

It is no small accomplishment to boil down essential facts, and state them in such simple English that they are brief and easily understood. This is the task Miss Cadmus set herself. Every page is an evidence of her success, perhaps no where better shown than in the section on "Maternity Nurse Visiting" and the "Advice for Mothers." Miss Cadmus has rendered a real service in giving this book to nurses.—C. E. G.

MAN—THE ANIMAL

By M. W. Smallwood, Ph.D., Howard Professor of Comparative Anatomy, Syracuse University.²

"Man—The Animal," a brief book by Dr. W. M. Smallwood, professor of comparative anatomy in Syracuse University, is a popular summary embracing the most recent discoveries of modern biological science. The author frankly sets forth the limits which scientific investigation has reached at various points and presents the biological view of life, disease and death with remarkable lucidity. The general character of the book's contents may be gained from the titles of three or four of the chapters: Laws of the Living Protoplasm; The Biological Unit; What Makes Man Go; Heredity; The Laws of Sensation and the Nervous System of Man; Biology and Progress. It is a popular science of a sort that hospital superintendents, nurses and social workers have long desired and is worth careful perusal.

TEXT-BOOK OF THE PRINCIPLES AND PRACTICE OF NURSING

By Bertha Harmer, B.Sc. (Columbia University), R.N., Instructor of Theory and Associate Instructor of Practical Nursing, St. Luke's Hospital Training School for Nurses, New York; formerly Instructor of Theory and of Practical Nursing, and Supervisor of Nurses, The Toronto General Hospital Training School for Nurses, Toronto, Canada.³

This book challenges attention and well rewards serious study. It is quite unlike all former texts on nursing procedures, because it emphasizes and connects the underlying principles with the practical work in a way that is unique.

Now that this has been done one wonders why it has not been done before, for there has been a demand for

¹G. P. Putnam's Sons, New York and London, The Knickerbocker Press, 1922.

²The MacMillan Company, New York, 1922.

³The MacMillan Company, New York, 1922.



The Johnson Pneumatic System of Temperature Regulation contains within itself all the elements that go to make a good investment for hospitals. Its never failing, instant response to the delicate degree changes of heat and cold in each room affords an actual saving in the consumption of coal equal to much more than the interest on the cost of the entire installation.

JOHNSON SERVICE COMPANY, MILWAUKEE



just such a book for many years. The reason is not far to seek. To accomplish this task it was necessary to merge the over-emphasized loyalty due to any one school, or group of nurses, into the larger loyalty that stresses the fundamental needs of all schools and all nurses. This has been done so successfully that the book is refreshingly free from *isms*, and from overemphasis on the approved practices of any one school. The aim as stated in the preface is "to impress upon the student the fundamental principles of nursing, founded upon the ideals of service, its object being not only to help cure the sick and heal the wounded but to bring health and ease, rest and comfort to the suffering mind and body. Secondly, to emphasize the underlying principles of each practical procedure or technique."

It is quite evident that this clear-cut aim was constantly uppermost in the mind of the author, for every page bears evidence of it.

Two outstanding features of the book are the sequence and the completeness of the material presented. By sequence it is meant that the most elementary and most frequently used procedures are presented first, and there is a definite connection between one procedure and the next, as well as a steady advance from the simple to the more complex. In other words the principles of teaching have controlled the arrangement of the subject matter. This in itself is unique, because all too often nursing texts have shown how definitely the exigencies of work have controlled the teaching. The completeness is such that the book contains not only the fundamentals in nursing, i.e., the nursing care and treatments used in general medicine and surgery, but also the nursing care and treatments used in diseases of the eye, ear, nose and throat.

The illustrations are clear and helpful, as well as generous in number.

In an address made in 1917 by Miss Nutting may be found the following statement: "Just as improvements in the practical methods of nursing must be brought about by those who do the work, so the intellectual aspects of nursing can only be developed and presented by nurses who can see all that is involved of that nature in their own work." The author of this book has had the vision to see and the ability to present all that is involved in so-called practical nursing, and has thereby made it all the more practical.—C. E. G.

OBSTETRICAL NURSING

A Text-book on the Nursing Care of the Expectant Mother, the Woman in Labor, the Young Mother and Her Baby. By Carolyn Conant Van Blarcom, R.N., Formerly Assistant Superintendent and Instructor in Obstetrical Nursing and the Care of Infants and Children at the Johns Hopkins Hospital Training School for Nurses; Author of "The Midwife in England." With 200 illustrations and eight charts.⁴

This text-book is a welcome addition to the growing list of books written "by a nurse for nurses," and nurses may well be proud of this fact because it is an unusually good presentation of a subject, about which there has been no dearth of good books.

The author has had a wide and varied experience, which probably influenced her aim—to produce a book that would "be helpful to, and widen the outlook of all nurses, no matter where or by whom trained." Consequently the emphasis is on the underlying principles of obstetrical nursing. Not one method, but a "survey of nursing methods employed in maternity wards and hospitals of recognized

excellence is presented." This is as it should be, for it is essential that student nurses should be taught not only the particular method in vogue in one school, but other equally good methods used elsewhere, for nurses must be able to analyze the advantages of different methods and choose the one most adequate for the satisfactory care of the mother and child in any environment in which they may be found.

The book is divided into seven parts, the first two of which deal with the normal anatomy and physiology of the female generative tract. Four of the succeeding parts are devoted respectively to a description of the nurse's duties during pregnancy, labor, the puerperium and early infancy. A separate part is devoted to a description of the organized care and instruction of maternity patients by public health nurses. Each part is unusually complete and well illustrated. In fact the illustrations, drawn as they are from so many sources, bear witness to the author's statement that she spent a year and a half studying the training given in maternity nursing in several hospitals in this country and Canada.

There are so many excellent features that it is difficult to select those worthy of special mention without making the list unduly long. But in even a casual examination one cannot fail to be impressed by the attitude which pervades every page, an attitude which is best expressed in the author's own words as an attempt "to give young nurses something of a feeling of reverence for the great mystery of birth" and "an appreciation of the significance of the event in which they are participants." It is no small achievement to have written a text that is pre-eminently scientific and practical, and yet dominated by such spirit. This in itself is enough to make Miss Van Blarcom's book an exceptionally satisfactory one to place in the hands of students, and justifies all nurses in being proud of her accomplishment.—C. E. G.

HANDBOOK OF ORGANIZATION AND METHOD IN HOSPITAL SOCIAL SERVICE

An Outline of Policies as practiced at the Johns Hopkins Hospital, Baltimore, Md. By Margaret S. Brogden, Chief of Social Service, the Johns Hopkins Hospital.⁵

Policies worked out in the social service department of Johns Hopkins Hospital in the thirteen years since that department was founded make up the contents of a handy volume by Miss Margaret S. Brogden, recently published under the title, "Handbook of Organization and Method in Hospital Social Service." The work is highly serviceable and it will undoubtedly become a standard reference book on social service practice.

In addition to a plan of organization and methods of procedure, outlined in the text matter, is a complete set of forms and records which with modifications might be adapted with benefit by many social service departments in hospitals, large and small. Miss Brogden, who is the chief of social service at Johns Hopkins with eighteen assistants, undertook the work singlehanded at its inception and her experience and conclusions cannot help but carry weight in the field of medical social service.

Almost every item that is of interest to the executive inaugurating such a department is treated of in the volume in a lucid and concise manner. The handbook should also be of value to teachers and students in schools of social work and to new workers, since it shows clearly the intimate relationship between hospital administration and department records.

⁴The New York MacMillan Company, 1922.

⁵The Norman, Remington Co., Baltimore, Md.